THE MEDICAL COLLEGE OF GEORGIA

TODAY

Georgia's Health Science University Autumn 1987 Vol. 16, No. 3

EDUCATION
RESEARCH
Approximately 233 research projects have received $11 million in support funds.
PATIENT CARE
Nearly 20,000 patients are admitted to the hospital each year, and outpatient visits total about 225,000.
A $2.5 million magnetic resonance imaging unit is operational with plans for a second unit.
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1987 Annual Report

Welcome to the 1987 annual report issue of the *Medical College of Georgia Today.*

In this issue, we look to the past, present and future; to the people and programs who daily impact upon patients, students and the knowledge base of science, health care and dentistry.

We visit with Dr. Robert Ellison, a pioneer in thoracic and cardiac surgery. His distinguished 40-year career is filled with the type of accomplishments that have helped make MCG great.

We meet Dr. Rebecca Birchmore Bedingfield. She shows us that dreams do come true—if you are willing to work very hard.

We meet two researchers. Dr. Gary M. Whitford is exploring the role of fluoride in preventing cavities in teeth that have yet to break through the gums. Dr. Peter J. Hornsby works to understand the aging process at the level of the cell.

We meet Rose Johnson, a nurse who devotes her own time to help fellow nurses struggling to overcome drug addiction.

I hope these stories and others will give you a taste of the people and work that is the Medical College of Georgia.

The remainder of 1987 and the following year promise challenges for all of us here.

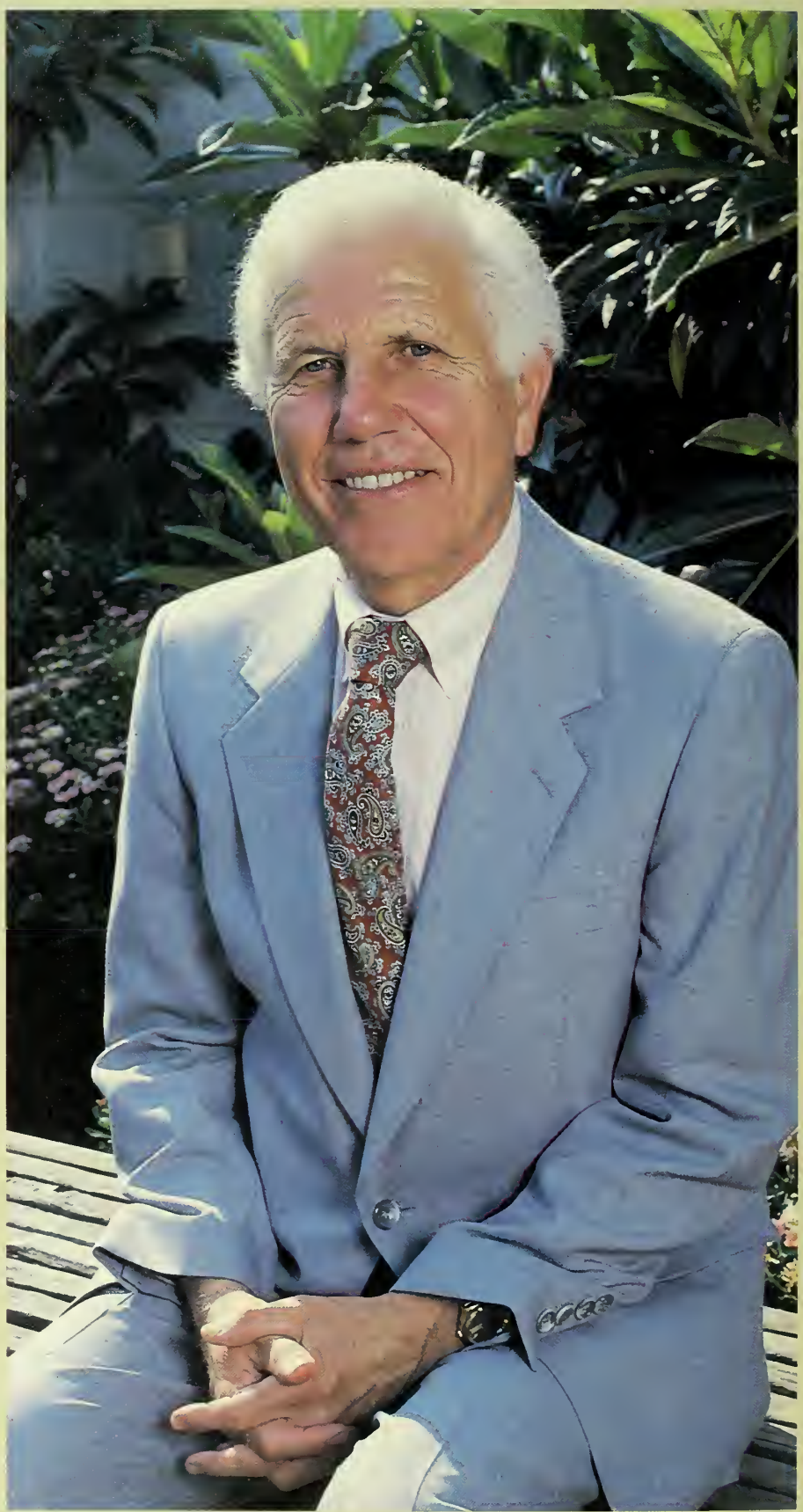
We have lost a president, Dr. Jesse L. Steinfeld, whose health problems forced his resignation June 30, 1987. There have been other top-level administration changes. But MCG will not lose the ground gained during Dr. Steinfeld's presidency and we will not stop moving ahead. We cannot stand still because too much important work remains ahead of us.

I hope that you will give our faculty and staff your support and good wishes during this period. We all want to make you proud of Georgia's health sciences university.

Sincerely,

Judson C. Hickey

Dr. Judson C. Hickey,
Acting President



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THE MEDICAL COLLEGE OF GEORGIA TODAY

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The Medical College of Georgia is the health sciences university of the University System of Georgia. Focusing on health care education, research and patient care, the Augusta-based institution consists of MCG Hospital, more than 80 support clinics, statewide outreach programs and the Schools of Allied Health Sciences, Dentistry, Graduate Studies, Medicine and Nursing.

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FORTY YEARS AT MCG

AFTER FORTY YEARS, MCG'S PREMIER SURGEON WANTS FORTY MORE

Toni Baker

Dr. Robert G. Ellison remembers seeing his father freeze in his tracks.

He'd just stand there or find the nearest chair.

Young Robert Ellison knew what that meant.

John Gordon Ellison's heart was crying out for oxygen.

He'd pop a nitroglycerine pill and wait for the pain to pass.

Robert Ellison was still in high school at the time. Still he knew enough to know that there was nothing that could be done for his father.

Thirteen years after his first heart attack, John Gordon Ellison died.

There was still little that could be done for him then.

But in the years since, his son has made the difference for thousands of other fathers, mothers and children.

"The fellows who come in today as residents, they walk in down there for an open heart procedure and everything just falls in line for them," Dr. Ellison said.

"They have little understanding of what led up to this. I enjoy talking with them about it, but it's hard for them to understand.

"I came up in the old days. If something didn't work, you'd get a piece of wire, put it together and make it work."

The dynamics of surgically repairing the heart and lungs attracted the recently retired chief of thoracic and cardiac surgery at the Medical College of Georgia.

He also was intrigued by a tall, red-haired "24-hour" thoracic surgeon named Bob Major.

Dr. Ellison's story begins Dec. 4, 1916, in Millen, Ga., where he was born and in Fairfax, S.C., where he spent some of his growing up years.

His stepgrandfather was a general practitioner who owned a drugstore. His mother, Frederica Fisher Ellison, was a college graduate who wanted her son to be a doctor.

Dr. Ellison was too young to know what he wanted.

It was the early 1930s. He was finishing up high school. His father was recovering from his first heart attack. Everyone was struggling with the Great Depression.

"Finances were tough. My father had managed not to go into bankruptcy or shoot himself," reflected Dr. Ellison.

He worked in a gas station and nearly paid for his first year at Middle Georgia College. A year later he transferred to Junior College of Augusta, now Augusta College.

By this time he was pre-med and it looked as though his mother would get her wish. He had two enjoyable years at Augusta College. Then he got a scholarship to Vanderbilt University, where he earned his degree in biology and chemistry.

It was time to apply for medical school and Dr. Ellison had two choices—Vanderbilt University and the University of Georgia School of Medicine (now MCG). Both schools chose him.

Times still were difficult financially. People he respected told him he could get a good education at either place. He came back to Georgia.

That decision was a first step toward a lifelong relationship between a young man from Millen and Georgia's medical school.

MCG had a different face in the late 1930s and early 1940s.

The old University Hospital was the teaching hospital. Neighborhoods surrounded the campus and families took in students as boarders. Dr. Ellison lived in a house where the Student Center now stands.

The educational process was different. Medical students did not get as much clinical exposure as early as they do now. That fact had its critics. Dr. Ellison was among them.

Exposure to patients gave application to the information they learned, he said. "All medical students at that time thought it was too much science and not enough art of medicine. But you had to keep your cool. At that time, if you flunked out of medical school, you knew where you would end up: the front line with a gun in your hand."

But despite the imperfections, Dr. Ellison found himself in a world he loved. He was one of 48 students who started as freshmen. He was one of 43 who finished as M.D.'s. Six students were Alpha Omega Alpha. One of the six was Dr. Ellison.

Enter Dr. Major.

Dr. Ellison's experience with his father's heart trouble frustrated him as a son, but did not inspire him to be a surgeon.

The fact that little could be done for his father meant that little was known about the field.

But the tide was beginning to change. Dr. Major was part of the change.

He was the first thoracic surgeon in the Southeast. Atlanta was his base in the early 1940s but Dr. Major was running across Georgia to care for tuberculosis patients. During his travels, he met Dr. Rufus Payne, a young doctor working in public health.

"They connived," Dr. Ellison said. "Dr. Payne was selected director of the state tuberculosis center in Alto, Ga. He had in mind the state taking over Battey General Army Hospital in Rome at the close of World War II. Alto was limited by 500 beds, not nearly enough for the rampage of TB."

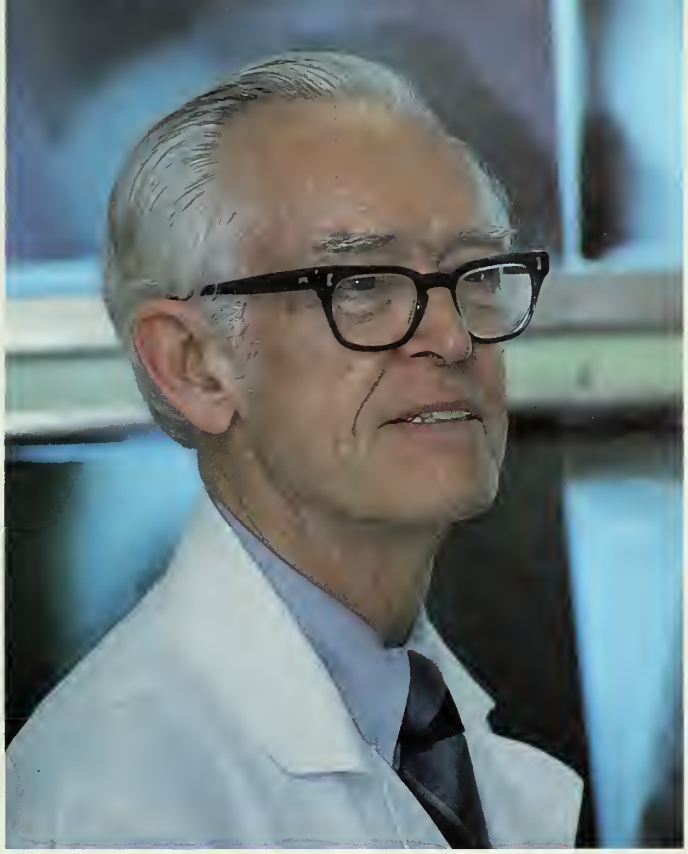
The two got what they wanted. Battey opened as a TB center in July 1946.

But Battey was only a part of the plan.

Affiliations were established between the new state sanitorium and the medical school in Augusta.

The availability of huge numbers of patients at Battey made it possible to start a thoracic surgery residency at MCG.

By this time young Dr. Ellison was finishing up his general surgery residen-



cy and was fascinated by thoracic surgery.

The man most responsible was Dr. Bob Major.

"It was his commitment. He was sort of a hero," says Dr. Ellison. As a surgery resident, Dr. Ellison saw this man a great deal, at times working as his third or fourth assistant.

Dr. Major was tall, gawky and red-haired. But inside was the soul of a surgeon.

"There was only one thing on that man's mind and that was to cure a patient," Dr. Ellison said. He called him a 24-hour surgeon—his body and mind nearly always consumed with work.

"He had a very strong temper," Dr. Ellison said. "Even those who loved him took a verbal beating from him on occasion if he thought you were not doing just right."

He was a role model. He was an excellent clinician and he inspired the same in Dr. Ellison, who isn't sure his life would have followed the same track otherwise.

Dr. Major became chief of the new thoracic surgery program at Georgia's medical school and Dr. Ellison became his second resident. Dr. Ellison ended up the first to finish, when the first resident developed TB and had to drop behind.

"Things were happening then," Dr. Ellison said. "So many new developments were coming along. It was just an exciting time."

Dr. Ellison enjoys looking back on the roots of today's highly-sophisticated field of thoracic and cardiac surgery.

His stories go back to days before heart-lung bypass machines. Young patients had to be packed in ice, their body temperatures cooled, their oxygen needs decreased, the blood supply to the heart shut off. Then a doctor had maybe 10 minutes to repair a simple congenital heart defect.

Repairing those defects was the first and only heart surgery available for awhile.

"I really initially was very fascinated by cardiopulmonary physiology. I was real excited about it. It was not cut and dried. It was dynamic to me."

Dr. Ellison remembers the first attempts at taking over the work of the heart with finger pumps and crude oxygenators.

He remembers implanting the first heart valves, knowing they probably would not last a year.

Experience has given Dr. Ellison a very real appreciation of technology today: monitoring equipment that details heart activity, the "Rolls Royce" of heart bypass machines that oxygenates much like the lungs, and mechanical valves that function indefinitely.

As the 1940s closed, Dr. Ellison completed his thoracic surgery residency, squeezing in two months of additional training in cardiopulmonary physiology at Bellevue Hospital in New York and a six-month pathology rotation in Augusta.

This training was self-prescribed. Those extra months gave him exposure to doctors doing pioneering work at places like Johns Hopkins, the Mayo Clinic and the University of Minnesota.

Dr. Ellison says the extra months weren't work. It was fun that led to an ever better understanding of how the body works.

At MCG, he moved from resident to thoracic surgery faculty and finally to chief of the section of thoracic surgery in 1955.

Dr. Major, his mentor, left MCG and later moved to New Mexico. He died at 53 of heart disease.

Back on the home front, slow but steady progress was being made to develop the thoracic and heart program.

Dr. Ellison met, married and worked with Dr. Lois Ellison, a pioneer in development of MCG's cardiopulmonary lab, where the first catheterizations and blood gasses were performed.

Dr. Ellison did the first open heart procedures using bypass in 1956. The first two patients were children. He lost them both. One was a classic blue baby who could not get adequate blood flow to his lungs. The other had a valve abnormality between the atrium and the ventricles and a hole in the tissue between the two.

Discouraged with the state of the equipment and disheartened over the loss of two children, Dr. Ellison went back to experiment in the dog lab.

He developed a team of surgeons, anesthesiologists and nurses. "We did a dog a week. And the afternoon before, I'd meet for an hour or so with the group to go over how it would be done, outline the plan exactly. We would operate on the dog just like it was going to be a patient."

By the time the team had done 15 dogs, a new, better bypass machine became available. In 1957 Dr. Ellison went back to the operating room with 2-year-old Patricia Williamson. She had a ventricular septal defect. The operation went well. He still gets Christmas cards from her.

"I was apprehensive," he said of that first procedure, but he also was determined.

"I'd already made up my mind that I was going to do this. This is why I came full time to the Medical College. This is the career I wanted. It was exciting. It was new. I wanted to be a part of it. I'd been trained well technically and I thought I could do it. I wasn't cocky about it. I studied hard.

"My goal was to bring to the Medical College the state of the art in heart surgery," he said.

The times were exciting and frustrating.

"I was very frustrated in that we were limited in the number of cases we could do because of the capacity of the Talmadge Hospital. At that time, we were limited to two operating days a

Below: *Dr. Ellison and resident Dr. Bedford Boylston perform an open heart procedure.* Opposite: *Dr. Ellison conducts follow-up exam of patient Mattie Major.*

week," Dr. Ellison said.

In his efforts to improve post-operative care, Dr. Ellison established the first intensive care unit at MCG.

Through the years, the excitement and frustrations have never ceased.

As a man, Dr. Ellison says his greatest experiences have been his wife, Lois, and their five sons, Robert Gordon Jr., Gregory Taylor, Mark Frederick, James Walton and John Charles Ellison.

The family grew up close and supportive. If there was a struggle, it was simply that there never seemed enough time for everything.

Three of his five sons followed in their parents' footsteps and became doctors. One son is a lawyer and the other director of sales for a computer company.

As a doctor, Dr. Ellison considers the operating room his workshop and surgery his life. He is one of those lucky people who would not change his chosen profession if he could.

He sees his workshop as the ideal place for teaching, so he makes the most of hours spent there, sharing his knowledge and experience with young residents. He lets residents take the lead, as long as he agrees with their direction. He never forgets—and they never forget—that the patient is Dr. Ellison's responsibility.

"My whole professional life has been the residency training program and patient care," Dr. Ellison said.

Sixty-five residents have gone through MCG's thoracic and cardiac surgery program and Dr. Ellison has taught most of them.

"Dr. Ellison has managed to kind of become a father of cardiac surgery in his own lifetime," said Dr. James E. Chapman, who spent his last day as senior cardiac surgery resident on Dr. Ellison's last day as chief.

"He's the last of the Southern gentlemen surgeons. You don't see that anymore, people who are unflappable, a gentleman to the nurses, to the medical students, to the residents, to the secretaries, to everybody," Dr. Chapman said.

"The residents who come through here tend to take him on sort of like a father figure.

"That's unique. They are not so much afraid of him as they want to live up to his expectations. That's what keeps people going around here. I'm the same way. I see it that way. I've enjoyed being here because of that.

"He is one of the few people who can operate all day long, you know 15 or 16 hours, and never get excited or raise their voice at the nurses or have anything derogatory to say. He has something nice to say about everybody and yet he keeps everybody on their toes. There is no single simple way to describe how somebody does something like that. It's just their image.

"People respect him so that they want to do their jobs well without intimidation. He's famous in his own right, anyway, all over the country. That adds an aura to it also," said Dr. Chapman.

"There is an old saying, 'You never know how you look until you get your picture took,'" Dr. Ellison said. "It's hard to know how other people see you. I think I may be interpreted as being tough. If so, it's because I have high standards.

"I want the residents in training in our program to have high standards. I was trained that way. I may not do everything just right. I get frustrated with the residents sometimes and they get frustrated with me. I aim for excellence. I do my best (to get there)."

"He's maintained his technical expertise. The depth of his experience is outstanding," said Dr. Joseph W. Rubin, who has worked with Dr. Ellison since 1973 and who is now interim chief of the section. "He uses it on a daily basis with patients. He's been a superb teacher with students and residents alike. He's been a perfect associate and an exemplary leader," Dr. Rubin said.

No one disputes the fact that patients always come first with Dr. Ellison. "You'll never get me to say anything else," he says.

No matter how many times he has walked into the operating room, he has never considered it routine. "Every patient is an individual situation. You never take anything for granted."

Dr. Ellison leaves MCG proud of what he has accomplished as its second and longest chief of thoracic and cardiac surgery.

"I didn't do this by myself. I was the catalyst. I was the one who nagged people to death to get it going."

He has special thanks for people like Dr. William Moretz, chairman of the department of surgery in the early days; Dr. Walter Shepeard, then director of the blood bank; and his friend Dr. Payne, who became the first director of the medical college's hospital.

And for fellow thoracic surgeons, Dr. Tom Yeh and Dr. David Hall, who went through the training program, then stayed on to help him develop the open heart program.

Today, three heart teams operate every day, two at MCG and one at the Veterans Administration Medical Center. They work cohesively toward the same bottom line, excellent patient care.

The most common procedures these days are coronary bypass surgery, congenital heart surgery and valve replacements.

The two open heart operating rooms Dr. Ellison designed at MCG are stocked with the latest that technology has to offer.

Yet he says no one ever does everything he'd like.

And he would like to have done more.

He wanted a heart transplant program and made a proposal to MCG administration for a program six years ago. Nothing happened.

"I don't know where it got stopped." Maybe it was believed that the resources weren't available at the time, he said.

Dr. Ellison was in on the ground floor of transplantation, doing laboratory work on heart and lung transplantation back in the 1960s. He did not pursue it clinically then. "I sat back and watched what was happening at other places." At that time, Dr. Ellison chose not to pursue transplantation at MCG because the immunosuppressive drugs did not work well enough.

He believes cardiac and lung transplantation will come to the Medical College of Georgia. He believes he has laid the goundwork for it.

The field of surgery for heart arrhythmias is another he'd like to have pursued at MCG. He thinks this too will come.

"I wish I had 40 more," he says when asked about leaving MCG after 40 years. In his career, he only had transient thoughts of leaving. His roots are here. His devotion is here. "This is what I wanted. It was here. That never changed."

"I'm proud of the institution, the progress it has made in the time I've been associated with it.

"It's requiring some adjustment on my part having been here this period of time and having played such an active role in things for so long."

Is he sad? Not necessarily. "I think after being in charge of the service for 32 years, it's probably time for a younger person to take over."

Besides, he's not going far.

Dr. Ellison has taken a position on the staff of the thoracic heart surgery section at the Veterans Administration Medical Center, a program affiliated with the one he ran for so long.

He just had to walk across the street to get there.

He doesn't know when, if ever, he'll really retire.

"What would I do? This is my life."

HOWS AND WHYS OF AGING

Toni Baker

He first pursued an answer to one of cell biology's major questions.

Dr. Peter J. Hornsby wondered why egg cells always stick to their specific task as they develop into the tissues of a person or animal.

"A liver cell does not suddenly become a muscle cell, for example," said Dr. Hornsby, associate professor of cell and molecular biology at the Medical College of Georgia. "It would be chaos if it did."

Dr. Hornsby's specialty is growing cells for long periods in culture.

He found that even when he grew cells in culture, they started out maintaining their differentiated state.

"What happened was I found that when you put the cells into culture (to find out if they maintained their differentiated state) we found out to some extent they didn't," Dr. Hornsby said. "And the way in which they didn't maintain their differentiated state seemed to have a pattern to it."

"There were defined circumstances when one cell type could turn into another cell type. It was not entirely random."

It wasn't that—as he had said—liver cells would become muscle cells.

"They just weren't doing what they were supposed to do as well as they were supposed to do it," Dr. Hornsby said. "This is a function of time and the number of times the cells had divided in culture. So there's a time function and a cell division function.

"If they were supposed to be making a particular hormone . . . they either ceased to make that hormone entirely or they made a different hormone and the different hormone they made usually was a precursor of the one they were supposed to make," he said.

Gradually it hit him.

He was dealing with cell aging.

"The cells were aging, and in aging they were losing their abilities to perform their correct differentiated functions."

Dr. Hornsby never forgot his original question.

But he took a detour that steered him away from embryology and toward the other end of life's spectrum—aging.

It has proven a successful deviation.

"We have developed a model for studying cell culture aging," says Dr. Hornsby, whose work recently earned him a MERIT award from the National Institutes of Health's National Institute on Aging. The MERIT Award is given to researchers with long-term NIH grant support and demonstrated superior competence and productivity.

"What we have found by studying this model is that a particular gene appears to be switched off in an irreversible way as cells age," he said.

This had never been shown before.

"No one actually has studied an individual, well-defined gene and its function with respect to cell culture aging and found the gene is switched off . . . and can't be switched on again," the researcher said.

"Although we have known that certain functions change with respect to length of time or number of doublings (divisions) in culture, and growth is the one that has been very well studied, still nobody knows what the gene is that is responsible for stopping the cells from growing.

"We have taken the opposite approach to start out with a gene, rather than a general function like growth, and look at one particular gene and found that its switching behavior resembles an aging process," Dr. Hornsby said.

"For biologists it's like here is a biological problem and it requires an explanation."

He hopes that his model and his other findings at a cellular level will help unlock the many mysteries of the aging human body.

It's well known that the body and its organs and tissues decline with age and there are theories as to why this happens.

"We want to establish why it happens," Dr. Hornsby said.

He likes to use the analogy of the study of viruses that led to the discovery of viral oncogenes and their relationship to cancer.

"In research on aging we are where people were in research on cancer at least 15 or 20 years ago. You have to look for some model system where you can understand the molecular mechanism first. Then you can go back and look at the whole animal and see whether the same mechanisms apply.

"It remains to be proven as to what relationship there is between cell culture aging and real aging," he said.

The decline in organ function with age may or may not be related to the decline in function of individual cells.

Scientists, including those with funding agencies such as the NIH, want that question answered one way or another.

And Dr. Hornsby has developed a model that may help answer it.

"What we decided to do is focus on one single gene which loses its expression in this model cell culture aging system."

The gene is called steroid 17-alpha-hydroxylase.

He selected this gene because its loss of expression looks like aging. If a gene loses its expression quickly

after being placed in a cell culture, the decline may be related to depriving the cell of some nutrient or hormone in the body.

But this steroid 17-alpha-hydroxylase deteriorates in function in about six months.

"We are trying to find out why the gene gets switched off. What we have found is that if one looks at individual cells, and this is the first time that anyone has done this, that you find it does suddenly stop working in a single, individual cell.

"If you look at the function of the population of cells as a whole, the population of cells you have in the culture dish, you see the level of expression of the gene going down constantly. But, if you look at the level of expression in individual cells, you find that it either appears to be on or off.

"What happens is that the number of cells expressing the gene decreases as a function of time."

That finding is a recent one made possible by some new techniques developed in Dr. Hornsby's laboratory to allow examination of gene expression in individual cells.

Now the question has arisen: is the decline in gene function caused by a gradual fading of the gene's ability to function or is it a switch that turns off the gene?

Dr. Hornsby thinks the gene is switched off, but he is not sure yet how that happens.

To pursue this problem further, Dr. Hornsby has used a process called transfection in which a cloned gene is put into a cell type in which the gene is not normally expressed.

"What we have done is to put in a gene which makes the cells grow much more strongly than they did previously and so extend the period for their doublings and extend the period they will live and grow outside the body," Dr. Hornsby said.

He was able to take old cells that had lost their gene expression and revive the growth of those cells but not the function. The function of the cells never returned.

"What it means is that the switch is truly, essentially an irreversible switch," he said.

Now, Dr. Hornsby wants to know the molecular mechanism for switching off the gene.

"If we find it, and that is a big if, that will be the first time that anyone has any kind of molecular mechanism for switching off any gene in aging," he said.

The simplest theory, and perhaps the correct one, is the molecular wear and tear that comes with time.

"Whether a particular cell is expressing a particular gene depends on the proteins which are attached to that gene in the cell. It doesn't matter whether the gene is present in the cell because all cells have the same genes, but they are not being expressed in all the different tissues of the body the same way," Dr. Hornsby said.

It may be that the protein just gets old and no longer does its job of activating a gene.

"I think at some point the gene is switched off and that might be because the proteins have become old. The proteins don't get rejuvenated even though the cells may divide many times after that," Dr. Hornsby said.

Almost all cells in the body, except for specialized cells like neurons, divide constantly throughout life.

"Even if we transfect the old cells with an oncogene and revive their growth, their growth rate revives up to what it was in a young cell, and yet the gene does not get switched back on.

"What we are talking about here is a great molecular mystery for molecular biologists," he said.

The clues that Dr. Hornsby uncovers may not only help improve the understanding of aging, but also may prove helpful in determining causes of age-related diseases such as Alzheimer's.

Harry Jacobs (right) displays replacement pipe as resident engineer inspector Brent Richards holds corroded pipe.

Toni Baker

MASTER PLAN FOR PROGRESS

Throughout the rambling Medical College of Georgia Hospital and Clinics are the distinctive sights and sounds of progress.

Behind the Talmadge Wing, a two-story anatomic pathology addition rises from the ground.

The $2.2 million facility replaces the old anatomic pathology space located on the first floor of the Talmadge Wing.

Dr. Raghunatha Rao, chief of the section of anatomic pathology, says a hodgepodge of improvements to the existing facility over the years had turned it into a catacomb.

The addition will mean better organized layout of office and laboratory space and a small net gain in square footage.

Modern, more private areas for autopsy, surgical pathology, the morgue and office space for anatomic pathology are included in the addition.

Pathology should be moving into its new space by the end of 1987, according to Harry Jacobs, assistant hospital administrator for facilities.

The 6th floor of the Talmadge Wing, which is mostly offices and laboratories, is being totally reworked. The new 6th floor will include a seven-bed coronary care unit, a 21-bed telemetry unit and a 35-bed medical-surgical unit, Mr. Jacobs said.

Once work on the 6th floor is complete, the plan is to begin renovations on the fourth floor of the Talmadge Wing, according to Dr. Lois Ellison, associate vice president for planning, hospital and clinics.

Work on the 6th floor should be complete within 14 to 16 months at a cost of about $2.3 million, Mr. Jacobs said.

A six-bed intermediate care unit also opened this year on the hospital's 5th floor. It was an addition that eased the load on the overburdened ICUs.

The magnetic resonance imaging center opened its doors late last year. The $3 million project on the hospital's first floor replaced a mobile unit housed across campus. The existing MRI area has room for a second magnet.

A new outpatient surgery center became popular quickly and plans already are underway for a larger facility. The center is adjacent to the operating room on the first floor.

Plans call for an expanded ambulatory treatment center with areas for not only day surgery, but also endoscopy, pain management and more, Dr. Ellison said. The new center also should have its own operating suites.

The center will be housed near the main entrance to the Talmadge Wing and likely will incorporate some areas vacated on the first floor by anatomic pathology, Dr. Ellison said.

A major project made necessary by the age of the Talmadge Wing has been replacing the hot and cold water piping. Workers found old galvanized pipe nearly blocked by a buildup of minerals over time. The old galvanized piping has been replaced with new copper pipe. The $1.1 million project was completed late in the summer, Jacobs said.

Another necessary but less visible project is installment of a damper system throughout the hospital. Dampers have been installed in wall channels, or chases, which enclose pipes and wiring. The dampers prevent fire from spreading via the chases.

Perhaps one of the more visible improvements to the hospital has been the gradual but continuous upgrading of the nursing units.

Other improvements include the addition of an isolation area for the pediatric intensive care unit, family consultation rooms for pediatrics and trauma, three new exam rooms for the ophthalmology clinic and improved EEG monitoring capabilities in neurology.

All renovation of existing facilities fits into a master plan which calls for future construction of new facilities, Dr. Ellison said.

A $37 million facilities plan calls for construction of an outpatient care center and a specialized care center, which will expand emergency and trauma service capabilities and add to the intensive care capabilities of MCG Hospital and Clinics.

DOING HER BEST

Becky Bedingfield does her best and then some

Toni Baker

She has many subtitles.

Call her a former tennis champion.

Call her a former computer programmer.

Call her the former director of a diagnostic lab for high-risk infants.

Call her a lawyer.

Just please don't forget the most important titles.

She is mother to Christy, Brad and Bud.

And she is Rebecca Birchmore Bedingfield, M.D.

Read between the subtitles and the story goes back to Athens, Ga., and to a famous father.

Fred A. Birchmore also is a lawyer, who happened to ride a bicycle around the world and write a book about it. Their Athens home held snake skins and stuffed animal heads, memorabilia from that historic bicycle journey.

Becky is the oldest of his four children. "He expected me to do things and I felt, naturally, I should do the things he expected."

In those early days, Fred Birchmore would hit tennis balls to his eldest and tell her one day she'd be great.

"When I beat the local champion, he'd say, 'One day you'll be great' like whoever the Southern champion was. Then when I beat her he'd say, 'One day you will be great like whoever the national champion was.' I never did beat her."

But she made it to sixth in the nation in doubles competition.

"He was always one to say, do your best," Dr. Bedingfield said.

And so she has.

June 6, 1987, she picked up the degree that made doing her best worthwhile.

In many ways the day was no different from most—hectic. All the children's clothes were on the bottom of some pile. Two of them needed a haircut. She had to dash to the store with two children to buy what they needed to complete an outfit. "It was down to the wire," she said.

They drove down Washington Road in her daughter's old Ford Escort, "which is doing it up right," she said. She had the presence of mind to pick up her "Big Chill" cassette, so that was blasting on the car stereo and everyone was singing.

She saw some of her classmates headed toward the Medical College of Georgia. She realized she was the only one already wearing a cap and gown.

She made it to the Augusta-Richmond County Civic Center just in time for the processional.

"I wanted to have time to sit and think, this is it, the culmination of all these years. I really wanted the luxury of waking up that morning to a sunny day and thinking about that all morning and really reflecting," she said.

But her classmates were joking and passing confetti.

Where was the emotion? When would it hit?

She was to have her moment, and it came on stage.

Dr. James B. Puryear, vice president for student affairs, and a good family friend, grabbed her hand. Dr. Terrence Kuske, associate dean for curriculum, another old friend, gave her a knowing smile and called out her name. She heard clapping and her children yelling, "Yeah, Mom."

"I thought, this is it, Becky. You are going to lose all your composure right here on the stage. Any self-esteem and composure you have gained over the years is going to be blown right here on the spot."

She didn't blow it. She made it across the stage. But she had that feeling. "It was almost too much."

That moment was a long time coming for Dr. Bedingfield.

But hers is a story of determination, love and the good sense and good humor it took to realize a dream.

First go back to Athens, when the aspiring college student opted to major in math. It wasn't that she really liked math.

"Somehow I wanted to do what I thought I could that would be the most challenging thing I could do. Somehow that challenge was important to me at the time. I thought that math would give me a foundation to build on to do more and more challenging things."

At the time, she wasn't sure what the foundation would build toward.

She had thought about medicine and loved the idea. She had all the classic symptoms of wanting to help people.

Then one day she was dissecting a pig in biology and she met Marvin Bedingfield. He was pre-med. They fell in love. They dated through their junior and senior years. They married after his first year of medical school at the Medical College of Georgia.

So she came to medical school, but as a Medical Dame.

"I sort of grew up with him in the medical profession," she said. She got a realistic view of medical school but remained intrigued. The thought of going to school never really left her alone. But the time never seemed right.

She would not ask her parents, who had three more children coming up, to pay for more of her education. So she entered graduate school at MCG instead and went to work as a biomedical statistical programmer, analyzing medical data for doctors who were going to publish papers.

She finished everything she needed for her doctorate in medical microbiology, except a year's worth of research needed for her dissertation.

But by then her husband had finished medical school and his internship and opted to go to Louisville, Ky., for his residency in orthopedic surgery.

At that point, her own education was secondary to staying with her husband. She salvaged a master's in medical microbiology and public health and went to Kentucky.

There she ran a diagnostic laboratory for high risk infants. One year later, their first child was born. She quit work about two hours before.

The next two children came in the next four years. She became a full-time mother. The family moved to Montgomery, Ala., for two years while her husband satisfied a commitment to the Air Force.

During those years, Dr. Bedingfield loved her full-time job as mother.

"Maybe I felt a little guilty about liking it so much. Since I'd been so academically oriented this was a nice break. I always had the feeling that a mother ought to be home with her children." Her mother had been home with her.

By now it was time for her husband to establish his private practice and they went to his home in Savannah, Ga.

They bought a house. She joined the Junior League. She became involved in the community, helping to bring public radio to Savannah and helping to form a performing arts alliance. They had a maid. The children went to private schools. She drove a Mercedes.

It was a picture book life in many ways.

"(But) there was always that unsatisfied part, that part that said, well, what about your plans?" She wanted to talk shop with the doctors instead of chat with their wives.

She looked around and realized that once she'd been at the forefront of knowledge about what was happening in medical microbiology. But knowledge had left her in its wake.

"I don't think I would have actually gone back to school but there would have been that part of me that said where is that career that you were going to have. But I don't think I would have done it because I was so satisfied as a mother and so satisfied as a wife."

Then the marriage began to fall apart and Dr. Bedingfield found it necessary to reevaluate her life.

"In the course of thinking about what has happened and why, people either remarry or develop a career," she said."

She began thinking of a career.

Just months before the marriage ended, she came back to Augusta to visit her sister, Linda Birchmore, who was in medical school.

She remembers a doctor's ex-wife who lived downstairs from her sister. She lived in a tiny apartment and watched television from a rocking chair.

Dr. Bedingfield did not want to sit out the rest of her life.

"This was the time to get the career I always wanted." She had a 20-year-old master's in medical microbiology which was little good to her. "I checked out all the possibilities and decided I would just go for it. I was pretty old, but why not? That was what I wanted to do and if I were going to spend the rest of my life doing something, it may as well be what I always wanted."

She had two years of pre-med courses ahead of her at Armstrong State College. But she would do it.

Then the final curtain came down on the marriage.

The realist in her knew she couldn't wait two years. She had to have something now.

Back to her father.

He was a lawyer. So were her uncle and aunt. That would be an acceptable profession if she could not get into medical school.

In five days, she found out what she had to do to get into law school at the University of Georgia and took the aptitude test required for entry. She soon discovered that students typically cram for months for this test. She walked in the exam room and found some fellow test-takers doing calisthenics. She wondered, fleetingly, if she hadn't made a mistake.

She passed the test.

A month later she was accepted at UGA.

She packed up her small family and headed back to Athens with her dream on hold—temporarily.

"What you are doing is getting a bird in the hand but you are not letting go of the trap." She looked in her children's faces and thought of the dreams she had for them. Her family was in Athens. They could help with the children.

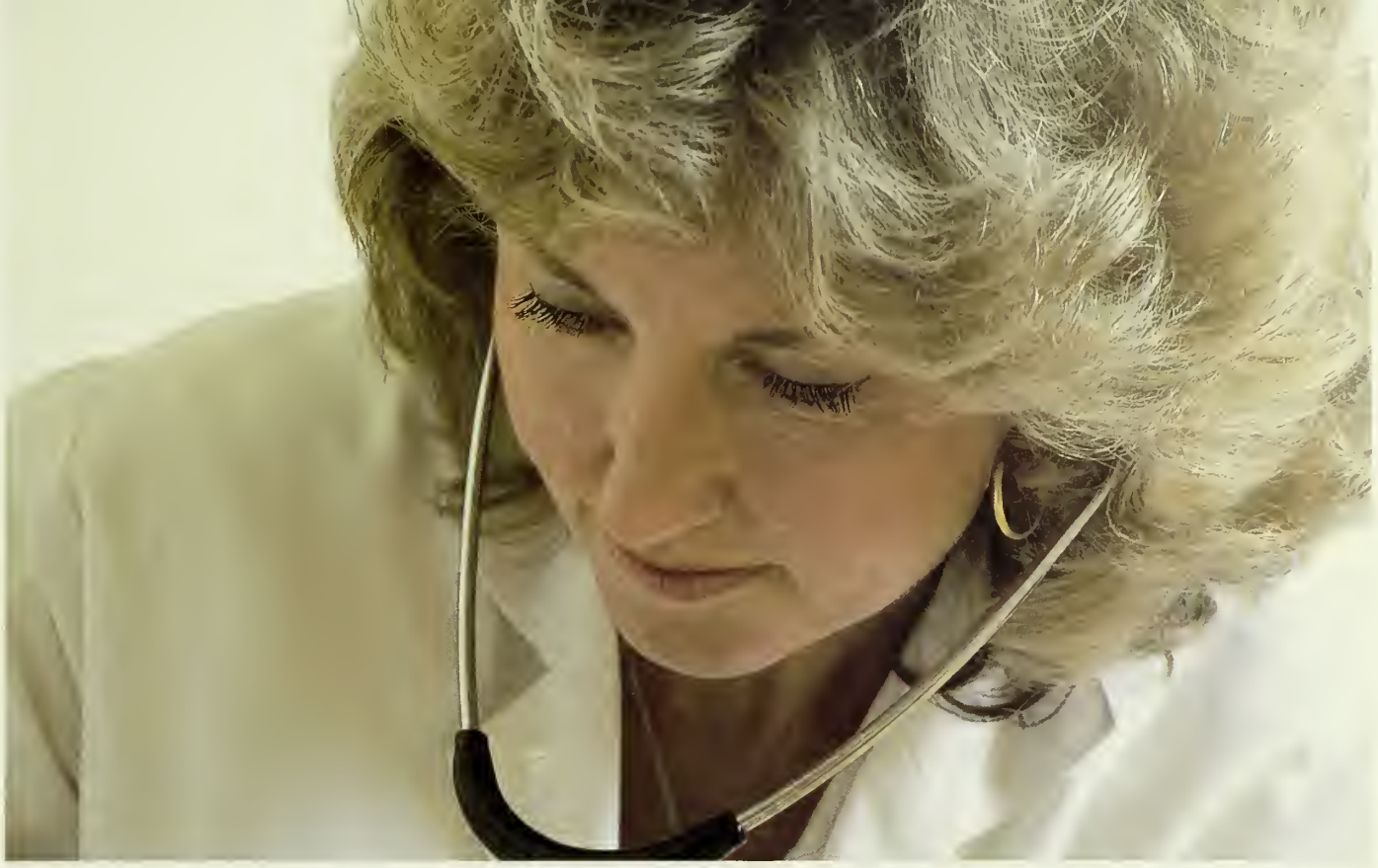
There was something else.

In Athens she could finish her pre-med requirements in about one fourth the time it would have taken in Savannah. So she took those classes in the summers.

"I knew that if I quit law school the third year I could do my pre-med courses a little bit quicker and get into medical school a little bit quicker."

She came back to Augusta after her first year of law school.

But she was not accepted at MCG.



Undaunted, she tried again. It worked. By the time she finished up law school it was time to start medical school.

She moved back to Augusta.

She found challenges. "How do you come in when you have a test the next day and get dinner for three kids? How do you get to their soccer games? What about when kids get sick?"

But the family worked out the problems with good sense and good humor.

Dr. Bedingfield cooked up huge dinners ahead and froze them. The small family was ecstatic when she learned how to vary the menu. She took her anatomy book to soccer games. "I would look up just in time to clap, then look back and study.

"We laugh a lot. We make a lot of jokes about the misfortunes that have happened," she said.

"I would take my kid down to the Research and Education Building and put him on the sofa if he felt too bad and didn't want to stay home alone."

She'd bring a pillow and blanket to school for herself and sleep during lunchtime so she felt refreshed for long afternoons. She started jogging and working out to raise her energy.

Time was found for school, her children and nothing else. She had no social life. "I'm probably a real nerd at this point."

But was she happy.

"It was like somebody who hasn't had a drink of water for a long time and you drink. It was just really, really satisfying to finally be, not only learning things that you always wanted to learn, but to be catching up on things that you might have known. It was like uncovering a big treasure chest of things that had been discovered," she said.

"I liked treating the patients. Part of it was having been married to a doctor and wanting to be a doctor myself and seeing him treat patients and saying look what I'm doing now, not to him, but to myself.

"I can start this IV and I can do this. Maybe it was achieving a goal. Maybe it was finding out that you did enjoy what you always thought you would . . . a confirmation of your ideals."

She calls herself idealistic, maybe to a fault. But she sees medicine as a profession where ideals can flourish. "That sounds kind of corny, but it's true.

"I just know one of these days I'm going to wake up and say, good Lord, what have I done? I did it with such intensity because I think I had something to prove to myself. Not only had I always wanted to go to medical school and here was the opportunity and this was the thing to do for my children, but there was some drive there that I can't put my finger on.

"I don't know what the source of the drive is, but there is something there that takes me home every day and makes me open the books and makes me study."

The children have been crucial to her success. "I could not have done either law school or medical school without them saying, 'Go mom.' They have done that all the time. They have been happy little cheerleaders."

She has embarked upon a year of internal medicine at MCG with hopes of going into dermatology.

It is her plan to practice medicine and use her law degree to be medicine's advocate.

During her first summer at medical school, she went to Washington to do a health fellowship with the Senate Committee on Labor and Human Resources. It exposed her to the workings of Medicare and Medicaid and safety in the workplace.

More recently she went to Atlanta and the state legislature where she lobbied to get students excluded from medical malpractice claims.

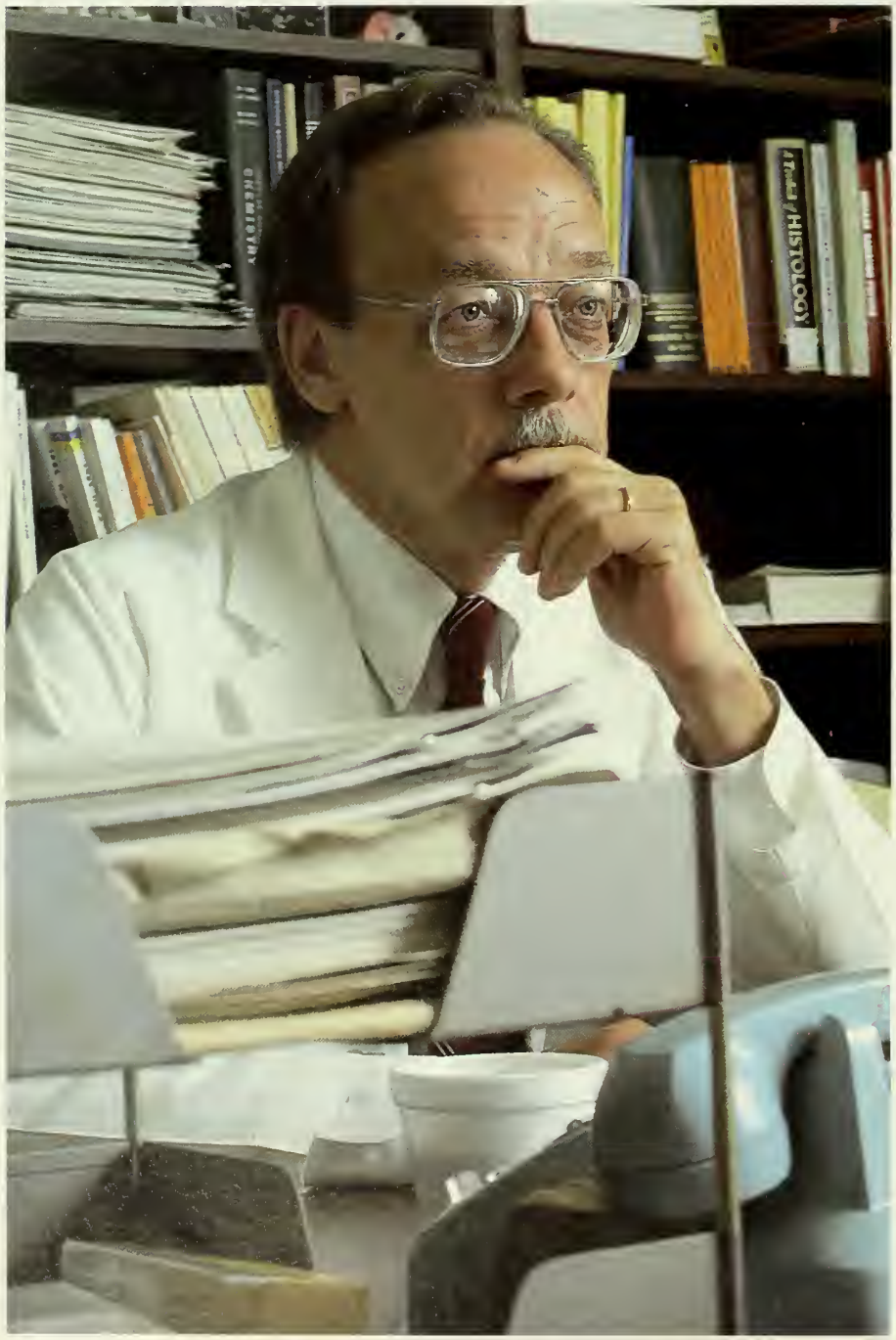
"There are so many things in medicine you would like to do something about. I might want to defend doctors some day."

As a physician, she is concerned about the increasing effect malpractice is having on her profession. "I'm sure it's going to affect me and I am going to say why don't we do something about that and at that time I'll be glad I have a law degree."

ANOTHER LOOK AT

FLUORIDE

Toni Baker



Dr. Gary M. Whitford is taking a new look at an old idea.

He is looking to see whether cavities can be prevented by giving fluoride to children whose teeth have yet to break through their gums.

"It seems that question already should be answered," said the Regents professor of oral biology in the Medical College of Georgia School of Dentistry.

In areas where the fluoride water level is low, the American Dental Association recommends fluoride drops or tablets for preeruptive teeth.

Pediatricans and dentists alike routinely prescribe supplements to prevent cavities once the teeth emerge.

"You would think that the answer already would be available after all these years. But it is not clear cut," says Dr. Whitford, who has studied various aspects of fluoride for 20 years.

If it is found that preeruptive fluoride gives teeth very little resistance to caries, there would be no reason to prescribe fluoride drops or tablets for infants and young children who do not have teeth yet, Dr. Whitford said.

"The teeth continue their development for many years," he said.

Baby teeth typically start breaking through the gum at about age 9 months. The first permanent molars begin coming in at about 6 years. Other permanent teeth, except for third molars which erupt at 16 years, grow into the mouth between the ages of 6 and 12.

In the 10th year of one of Dr. Whitford's two continuing grants from the National Institute of Dental Research, he and MCG colleague Dr. George Schuster want to determine scientifically whether ADA guidelines for the use of dietary fluoride supplements are justified.

The main question to be answered is whether fluoride swallowed, passing into the blood and taken up by developing teeth will help prevent cavities.

"Once the baby tooth or the permanent tooth has broken through the gum, then use of fluoride is known to prevent cavities," the researcher said.

Much is known and unknown about fluoride.

Fluoride has a place on the periodic table of the elements. It's been found in

the polar ice caps. It's in high concentrations in the ocean. It's in food. It's in every person and all water supplies, even those not purposefully fluoridated.

It's known that fluoride naturally migrates to the bones and teeth. A tiny amount is found in tissues and blood.

Dr. Whitford calls fluoride the single most important agent known for the fight against cavities.

It also is known that topically applied fluoride adversely affects the metabolism of bacteria found on the teeth so that bacteria produce less acid, which is responsible for tooth decay.

"When you swallow fluoridated water or use a fluoride toothpaste, that fluoride is in solution and it can be taken up by the bacteria sitting on the teeth. This prevents them from producing so much acid," Dr. Whitford said.

Fluoride also promotes remineralization of enamel. Each tooth has a thin, outer coating of enamel. A cavity starts when a piece of that enamel dissolves away. If sufficient amounts of fluoride are present, the fluoride encourages the dissolved minerals, mainly calcium and phosphate, to reform on the tooth.

"It helps maintain the integrity of the surface of the tooth. The fluoride inhibits the acid production which makes the enamel dissolve. During the dissolution process, which typically occurs to some degree during and after eating, the fluoride will help the process of remineralization," he said.

Fluoride may come from drinking fluoridated water or from using fluoride toothpastes, rinses or other dental products.

As teeth are brushed with a fluoridated toothpaste, the fluoride precipitates on surfaces of teeth. The fluoride doesn't penetrate far, but surface concentrations of fluoride are much higher in people who use toothpastes with fluoride.

Also, nearly everyone, especially children, swallows some toothpaste and that fluoride works its way through the blood and to the saliva where it bathes the teeth.

So there is no question that fluoride does work. But questions do remain about all the ways it works.

"What we are getting at here is the identification of the target that fluoride actually is hitting," Dr. Whitford said.

Fluoride taken up by tooth enamel during its development is very strongly bound. Very little of it is available to go into solution to affect bacteria and promote remineralization, he said.

"It's locked inside. So if the mechanism is hitting bacteria and preventing them from making so much acid, which is really one of the major theories about how fluoride works, then fluoride that was taken up during the development of the teeth really wouldn't do much good would it?" Dr. Whitford said.

To answer his questions, Dr. Whitford has designed a study using rats as models.

He will give rats fluoride supplements from conception to birth; from birth to weaning, while teeth are developing; and after the teeth erupt. Control groups will be built in.

All rats will be fed a diet high in sucrose and will be followed for about six weeks after weaning. Dr. Whitford then will look to see which group has the fewest cavities.

"So far our data indicates that if there is a positive effect of preeruptive fluoride, it is a minor one," Dr. Whitford said.

The MCG researcher is not yet ready to take a position on the value of taking fluoride tablets and drops before teeth emerge.

By the time he completes this latest study, Dr. Whitford should be ready to evaluate the American Dental Association's guidelines for the use of preeruptive fluoride. He hopes to complete the study by the summer of 1988.

Information Dr. Whitford gains from this study is just a part of the fluoride puzzle that he and other researchers are piecing together.

"It is a drug that we have deliberately added to water supplies since 1945, but like so many other substances it's a poison in high doses. It has enormous public health interest," Dr. Whitford said.

The MCG researcher already has found what he considers the most important discovery he may make.

He found that the efficiency with which the kidneys excrete fluoride is heavily dependent on the pH or acidity of the urine—a finding with important implications for the general metabolism and toxicity of fluoride.

"Its implications are manifold. As a result of that finding, I developed the general hypothesis that fluoride transport across cell membranes or across cellular epithelia such as the kidney tubule . . . is a function of the size and orientation of pH gradients between two adjacent solutions. That is a fundamental finding," Dr. Whitford said.

"If we know how fluoride distributes between the blood to the inside of a cell, if we know that the distribution is dependent on the direction and magnitude of the pH gradient and we also have a means of adjusting that pH gradient, then we can intervene in cases of acute toxicity, for example, and draw it out of the cells."

Fluoride toxicity can occur from swallowing too much toothpaste or too many fluoride tablets.

Fluoride migrates by diffusion from acidic solutions into more alkaline solutions, which means it can be drawn out of cells where it does damage in high concentrations. This is done by reducing the acidity or increasing the pH of the blood and fluid around the cells.

An easy way to increase the pH gradient across a cell membrane is hyperventilation. The blood pH immediately rises while the cell pH responds much more slowly. The pH gradient between the blood and the cells increases and fluoride is more attracted to the blood. Once in the blood, the fluoride can be excreted by the kidneys. Since the pH of urine also rises, the fluoride is more attracted to the kidneys.

Dr. Whitford first identified the process of fluoride diffusion from a more acidic to a less acidic environment in studies of how the kidneys handle fluoride.

His enthusiasm for fluoride research remains high.

"Fluoride is the cornerstone of modern preventive dentistry," he said. "We need to fully understand its metabolic and toxic characteristics as well as its mechanism of action so that the full impact of its beneficial effects can be achieved in the absence of unwanted side effects."

Below: *Rose Johnson*
Opposite: *Mary McCart talks about her experience as Mrs. Johnson listens.*

NURSES IN NEED

Gwen Corinth

Rose Johnson was the last to arrive at a dinner meeting recently. She walked into the dining room, and someone jokingly greeted her with, "Welcome to your intervention!"

Mrs. Johnson glanced around the room and realized that most of the faces were familiar. They were smiling, healthy faces. Not at all like the frightened, sick addicts they had been when she met them at "intervention" meetings, so called because they are the first step toward recovery from addiction to alcohol or drugs.

They were the faces of recovering nurses, learning to handle stress and strain without being high. Rose Johnson has been their advocate.

When Mrs. Johnson became a nurse advocate for the Georgia Nurses Association's Impaired Nurse Committee in 1981, she barely understood the terms "nurse advocate" or "impaired nurse." She was familiar with drug addiction from having worked a year with street addicts in the Community Mental Health Center of East Central Georgia methadone clinic. There she had learned the true nature of addiction.

"They really had a disease," she said. "They didn't use (drugs) because they were morally weak people."

She had graduated in 1967 from the University Hospital School of Nursing and worked seven years in coronary care. After returning to school at the Medical College of Georgia for bachelor's and master's degrees, she was hired at MCG as a psychiatric clinical nurse specialist, working with patients and their families on dealing with mental illness.

Mrs. Johnson also conducted stress management workshops for the nursing staff and began to counsel nurses individually. Coupled with her volunteer work as an advocate, she began to understand that nurses, the caretakers, also need care.

Mrs. Johnson has been chairman of the GNA's Impaired Nurse Committee for four years. It is volunteer work that often means spending time away from her husband and two teenagers. But it has been a source of tremendous pride—both in the program and in its "graduates," she says.

"It has enabled me to impact change not only throughout Georgia, but our program has become the model program for the United States," said Mrs. Johnson, a diminutive woman with striking blue eyes and slow, deliberate speech.

"It's also given me the opportunity to work with some of the most creative, intelligent nurses who really care about their peers," she said. "I feel really privileged to work with these people because I see such dedication for another peer who is ill."

People like Mary McCart, a recovering nurse who struggled with alcoholism for more than 20 years, whose children were taken from her and who has frequently opened her home to other recovering nurses.

"Mary is somebody I can depend on," Mrs. Johnson said. "I know she's going to help when I call."

"Some days Rose is my counselor. Some days Rose is my friend," said Mrs. McCart, now nurse manager of the chemical dependency unit at Heritage-Humana.

Guiding an addict back to health is a process that often begins in hostility and mistrust. When confronted, a nurse almost always denies being an addict, Mrs. Johnson said.

But in the six years that Mrs. Johnson has worked with the GNA's Impaired Nurse Committee, there have been mostly happy endings.

Approximately 150 nurses from nine counties in the GNA's 10th district (which includes Augusta) have been through the program, said Mrs. Johnson, one of three district nurse advocates. Between 40,000 and 75,000 registered nurses in the U.S.—6 to 8 percent of the nation's 1.9 million R.N.'s—are addicts. And substance abuse among health care workers is 30 to 100 times greater than in the general workforce, mainly because of the accessibility of narcotics. But Mrs. Johnson doesn't place much stock in statistics.

"Statistics are inaccurate," she said. "They are based on nurses in treatment. We have no idea how many are out there who are not in treatment.

"Chemical dependency is a problem in my opinion," she said. "If they're not treated, they will die."

Why are nurses vulnerable to addiction? Partly because of family background if a relative has been addicted to drugs or alcohol, partly because of the demands of the profession, Mrs. Johnson said.

"Chemical dependency is a way of dealing with problems," she said.

"She's working longer hours, her patients are sicker than ever before, and she's taking care of larger numbers of patients."

Then she may go home to problems with husband and family. Drugs become a way of coping with all of it.

The first step toward recovery is evidence of a problem. When a head nurse calls Mrs. Johnson to report her suspicions about a staff nurse, the two arrange a meeting to discuss the evidence.

Mrs. Johnson lists warning signals pointing to addiction: fainting, calling in sick after long weekends, taking long lunch hours alone, dramatic mood swings, incorrect narcotic counts. The evidence must be objective and it must include times, dates and places.

After gathering evidence, the head nurse arranges a meeting with the nurse in question. Mrs. Johnson is there, along with a recovering nurse.

The atmosphere can be volatile. The nurse may burst into tears. She may refute the evidence.

"But the intervention is done with love, with caring and respect for the person who has the disease," Mrs. Johnson said.

The goal is to get the nurse into a drug and alcohol treatment program of her choice. If she refuses treatment, subsequent infractions such as stealing drugs from supply rooms may lead to revokation of the nurse's state license.

While in treatment, the nurse works under a four-year restricted license. During the first two years, the nurse may not handle controlled substances. Next, she spends two years on probation—seeing a counselor, attending support group meetings and undergoing periodic drug screenings. If she successfully completes the four-year restriction, full licensure is restored.

As advocate, Mrs. Johnson supports, comforts, encourages and educates her "patients." And she sees changes occur over time, usually six therapy sessions. For long-term therapy, she refers the nurse to a practitioner in the community.

"I see their way of dealing with situations changes. It may be slow, it may be very simple, but their problem solving techniques change."

At first, she encourages the nurse to focus on expressing her feelings, then they talk about ways of coping with problems.

"It seems so simplistic, but for an individual never able to express herself, that is a tremendous amount of success," she said.

One clue of full recovery is "breaking anonymity"—when the nurse is able to tell others about her addiction.

"People who are dependent are taught to be secretive. It's a part of the disease," she said. "So a part of recovery is to be able to take responsibility for who I am."

Her voluntary advocacy seems a natural follow to her full-time work at MCG providing continuing education and inservice classes in such areas as stress management, depression and anxiety, relaxation techniques and creative problem solving.

Part of her job at MCG is to counsel nurses who come to her with personal or work-related problems. Nurses like 8-West head nurse Jan Murray.

"I see her off and on on a regular basis when the going gets rough—when the unit is very stressful and I want to quit my job," Ms. Murray said.

Recently, Mrs. Johnson has led group sessions on 8-West to help the nurses there deal with the deaths of pediatric patients with cancer, Ms. Murray said.

"She's good at summing up what you said," Ms. Murray said. "She helps you redirect some of your thinking in a positive manner when maybe all you think and feel is negative."

Friends speak of her sense of humor, her calmness in handling explosive situations, her commitment to family and work.

"At a difficult intervention. . . she's always the key person as far as having control over the situation," Mrs. McCart said.

Colleagues nominated Mrs. Johnson to succeed Rose Dilday, founder and first chairman of the GNA's Impaired Nurse Committee. She was at first hesitant to take on the challenge.

"We were hard pressed as to who would have the clinical respect as well as the willingness to carry on," Mrs. Dilday said. "She communicates competence and compassion. I think the thing that comes through is she knows the field."

"Once I got into it, it was just to me a fantastic idea and such an effective way to deal with people with this disease," Mrs. Johnson said. "That just made it all the more reason for me to work hard to get it going."

RECRUITMENT INTENSIFIES

RECRUITMENT EFFORTS INTENSIFY AS APPLICANT POOL SHRINKS

LIZ BEST

Some new terminology is being heard in certain administrative offices at the Medical College of Georgia these days. Words like "proactive," "comprehensive" and "aggressive" are being used to qualify phrases like "student recruitment plan."

Say what?

In past years, student recruitment was virtually unknown on this campus. It wasn't really needed and, as a rule, it wasn't done. But, it appears that the tables have turned.

The fact is that applicants for undergraduate programs of study at the Medical College are dwindling, in numbers and in excellence.

That's what prompted the Division of Student Affairs to hire a consulting firm, conduct marketing research and compile the results and recommendations into a master plan.

Dr. Bernie Abbott, director of student affairs and registrar, calls it, "a comprehensive, marketing-based student recruitment program."

The way Dr. Abbott sees it, the Medical College serves three groups of people with its graduates—the people of Georgia who receive health care, health care providers who need quality employees and prospective MCG students. Unless something is done to increase the number and quality of MCG applicants, these groups will not benefit from MCG graduates.

"We've had a steady decline in the quality and quantity of our undergraduate applicant pool," said Dr. Abbott. "The idea of the plan is to generate more and better applications to MCG in its undergraduate programs."

Another goal of the master student recruitment plan is to get the word out about the Medical College to a public largely unaware of the varied degrees available here.

Many people are not aware of the range of careers represented in the School of Allied Health Sciences, said Dr. James Puryear, vice president for student affairs. Some degree programs, such as dental hygiene and the radiologic technologies, are offered at many schools. The Medical College, however, is one of only a few colleges in Georgia to offer programs of study such as respiratory therapy and physician assistant.

"A lot of these fields, few people have ever heard of," said Dr. Puryear. He hopes that student recruitment will be a way to combat this ignorance.

Dr. Abbott hopes student recruitment will help get the word out about the Medical College in general.

"It's surprising how much ignorance there is about the Medical College of Georgia. Especially considering that we are the state's official health sciences university," said Dr. Abbott.

The National Institute for Organizational Research and Problem-Solving, a consulting firm in Ann Arbor, Mich., was hired in January 1986 to come up with possible solutions to the undergraduate enrollment problem. Their researchers came up with a four-part plan, much of which went into effect last July.

Phase One of the plan called for reorganization of the offices of the registrar and undergraduate admissions to create a third office for student recruitment.

The reallocation of admissions office funds is the objective of the next phase. As much of the budget as possible will be spent on recruitment efforts such as more telephoning, traveling and mailings. Included is a plan to create and distribute quality publications such as an attractive, eye-catching admissions catalog and a poster. New and improved graphics are part of the big picture as well.

Much of Phase Three involves recruiting through media. A new videotape on the Medical College is aimed at high school students and explains the availability, flexibility and possibility for good jobs and good pay in health careers.

A student recruitment newspaper, also aimed primarily at high schoolers, was published and distributed last summer to high school and college students, parents and school counselors around the Southeast. The newspaper contains feature articles on each health career offered through the School of Allied Health Sciences and the School of Nursing as well as various features on students, teachers and life at MCG.

The Medical College's Closer Look tours, now more than a year old, are part of Phase Three as well. The Office of Undergraduate Admissions conducts these tours every other Friday for high school and college students who are interested in health careers. Participants tour the campus, then split up and visit the departments of their choice to meet with instructors and counselors.

The fourth phase of the plan calls for a computer tracking system which will enable the office of admissions to keep tabs on prospective students over a number of years.

During the 1987/88 school year, representatives of the undergraduate programs at the Medical College will attend 47 college fairs around the state and will also increase visits to high school classrooms to present information on health careers and on MCG.

An early acceptance program to help eliminate the two-year delay dilemma, was begun by the undergraduate admissions office this fall. Under this plan, a student can be accepted to the Medical College immediately after high school, even if he first must complete one or two years of college elsewhere. Once those required courses are complete, the student automatically transfers to MCG.

Elsewhere at the Medical College, recruitment efforts are ongoing.

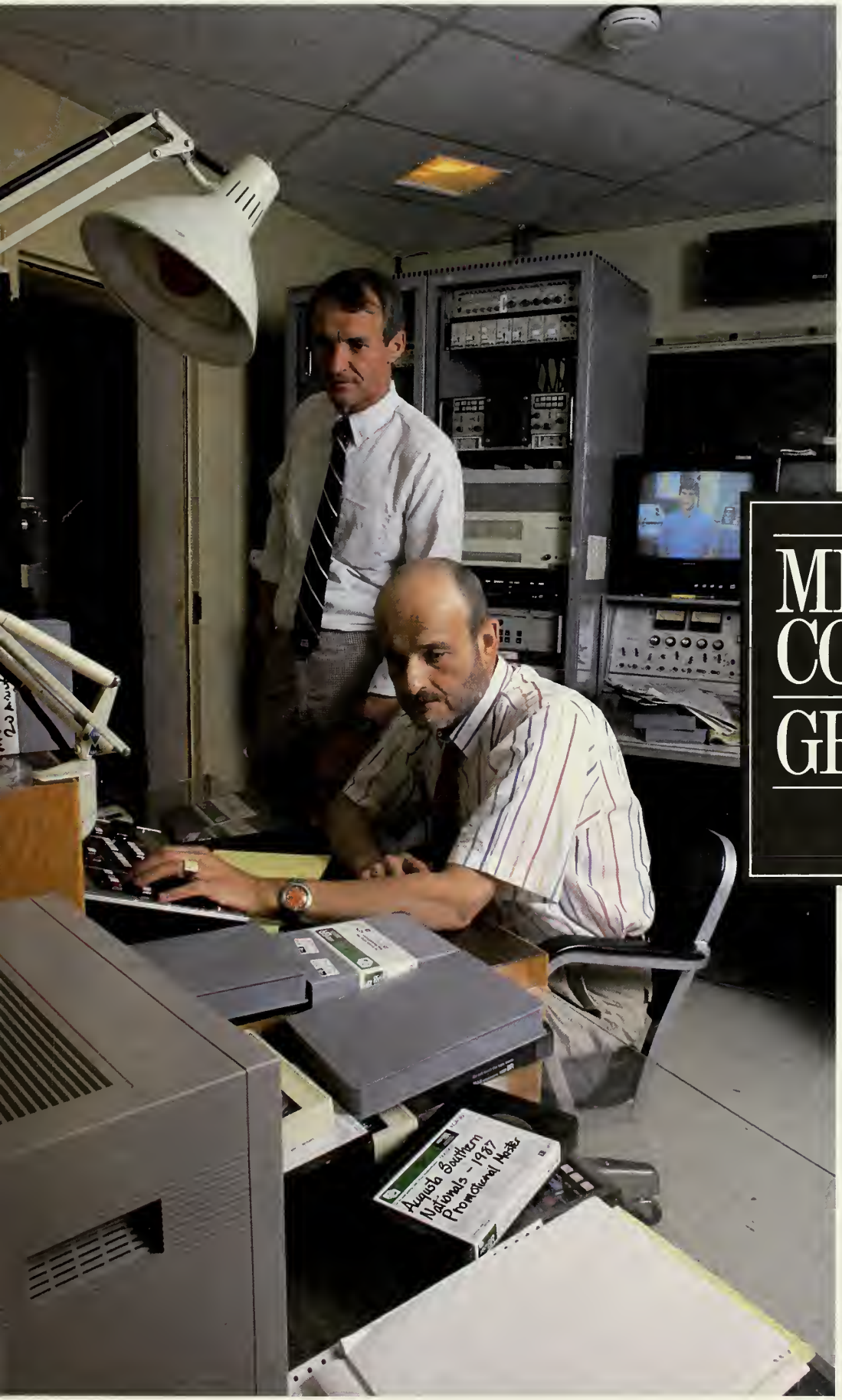
□The School of Medicine is taking part in an Early Decision Program in conjunction with the American Association of Medical Colleges Applicant Service, said Dr. Mary Ella Logan, associate professor in the Department of Pharmacology and associate dean for admissions.

Students interested in attending medical school apply to only one school between June 15 and Aug. 1. The school is then obligated either to accept or reject that student by Oct. 1, when the rejected student is free to reapply to the same school or apply to other schools of medicine.

Scholarship funds have been increased, which Dr. Logan feels is advantageous to recruiting students.

Last year, the School of Medicine, which accepts 180 students each year, had 1,018 applicants. This year the number dropped to 893, which is in keeping with the national trend.

Below: *Dr. Bernie Abbott (standing) and Bob Shaver review recruitment videotape.* Inset: *New logotype developed as part of the recruitment plan.*



"The national applicant pool has been decreasing steadily for a number of years. We are starting to follow that trend. We haven't been until now," said Dr. Logan, adding that even with fewer applicants, she is optimistic because qualified applicants are being turned away.

□The School of Dentistry for several years has relied on its recruitment partners program to attract students, said admissions committee member Dr. Mike Miller. Alumni of the dental school identify young people in their communities who are interested in dentistry, then encourage

THE MEDICAL COLLEGE OF GEORGIA

them to pursue that interest at the Medical College. The applicant pool increased by 5 percent this year, said Dr. Miller.

□The School of Graduate Studies is continuing its recruitment efforts toward the Board of Regents goal that 11 percent of students in all state graduate schools be black.

Another recruiting effort in the graduate school is a research day, said Dr. Lowell M. Greenbaum, dean of the school. Graduate students involved with research develop ways to display their research programs. About 60 undergraduate students from other institutions attend.

Rx for a good night's sleep

Gwen Corinth

It's 11 p.m., but still only twilight in Room 331 North of the Medical College of Georgia Hospital.

That means there's just enough darkness for a patient to drowse and fall asleep—despite the network of electrodes trailing colored wires from his head, despite the restless scratching of the polysomnographic monitor recording heartbeat, breathing, eye movement and other pertinent information.

He sleeps on, oblivious to the murmurings of technician and physician who have just noticed the unwavering horizontal line that means the patient is not breathing.

One minute passes. Two minutes. The physician steps to the bed and checks the clear plastic mask covering the patient's nose and mouth. It doesn't appear to have shifted. The patient's chest and abdomen continue to rise and fall. He is trying to breathe.

Two and a half minutes. The patient stirs and takes a breath.

Ten years ago, Dr. Bashir Chaudhary would have hustled the patient to intensive care where he could be monitored with help close by in case of emergency. Tonight, the technician simply marks the telltale line with a felt tip pen and continues her eight-hour vigil.

In 10 years, Dr. Chaudhary and the technicians of the MCG Sleep Disorder Center have learned not to panic when a patient stops breathing. They know the pause may last as long as three minutes, perilously close to the point of brain damage, but they also know help is only yards away at the 3 North nursing station.

They're also aware that brief pauses between breaths are characteristic of patients who have sleep apnea. Apnea means cessation of breathing. A healthy person may have a brief apnea—lasting but a few seconds—each hour of the night. A person with chronic, severe apnea may have more than five per hour, each lasting from 10 seconds to three minutes. Each apnea briefly wakens the patient (although he is not conscious of it) and leaves him feeling tired and irritable the next day.

Apnea is an insidious disorder which is rarely fatal but always troublesome. Apnea means fitful nights and groggy days, or in medical terminology, daytime somnolence. That, in itself, can be at best embarrassing—the sheriff who falls asleep while making an arrest—and at worst, deadly—the bus driver who falls asleep at the wheel.

During the early days of MCG's center, Dr. Chaudhary could perhaps sympathize with sleepy apnea patients. He and his collaborators could not afford to pay technicians such as the two who now rotate night shifts. So Dr. Chaudhary worked many weekend nights for a year interviewing patients, attaching electrodes, scanning printouts and evaluating data.

Since the center was founded, its staff has done about a thousand studies and is still doing about one per night.

The center was founded in 1978 through the collaboration of Dr. Chaudhary, whose specialty is pulmonary medicine; Dr. William Speir, chief of pulmonary medicine; Dr. Ahmad Elguindi, also in pulmonary medicine; and Dr. Don King, a neurologist. Now director of the center, Dr. Chaudhary was then fresh from a fellowship which included studying sleep disorders at the University of Kentucky.

MCG's sleep center was one of the first 10 founded in the United States and is still one of the largest. It was launched at a time when physicians were beginning to study apnea, learn its symptoms and devise treatment.

Understanding sleep disorders requires a knowledge of sleep, Dr. Chaudhary said.

Sleep is a restorative time of relaxation for the body. It is part of the circadian rhythm, recurring regularly within a 24-hour cycle.

Sleep can be subdivided into rapid eye movement sleep (REM) in which the eyes move back and forth and non-REM sleep. During REM sleep, the body passes through four stages from light to very deep sleep. The body may cycle back and forth between REM and non-REM sleep about five times a night. Each cycle takes 60 to 90 minutes.

During REM sleep, the muscles become flaccid, but the brain is very active synthesizing information absorbed during the day. Most dreaming occurs during REM sleep, typically during the early morning. If you wake during REM sleep, you can usually remember dreams.

Having occasional trouble sleeping is common, Dr. Chaudhary said. Treating average insomnia takes mostly common sense: avoiding coffee, alcohol and heavy snacks before bedtime; getting regular exercise and sleeping on a good mattress.

Dr. Chaudhary is interested, however, in more serious problems. Apnea, which causes excessive daytime sleepiness, is one.

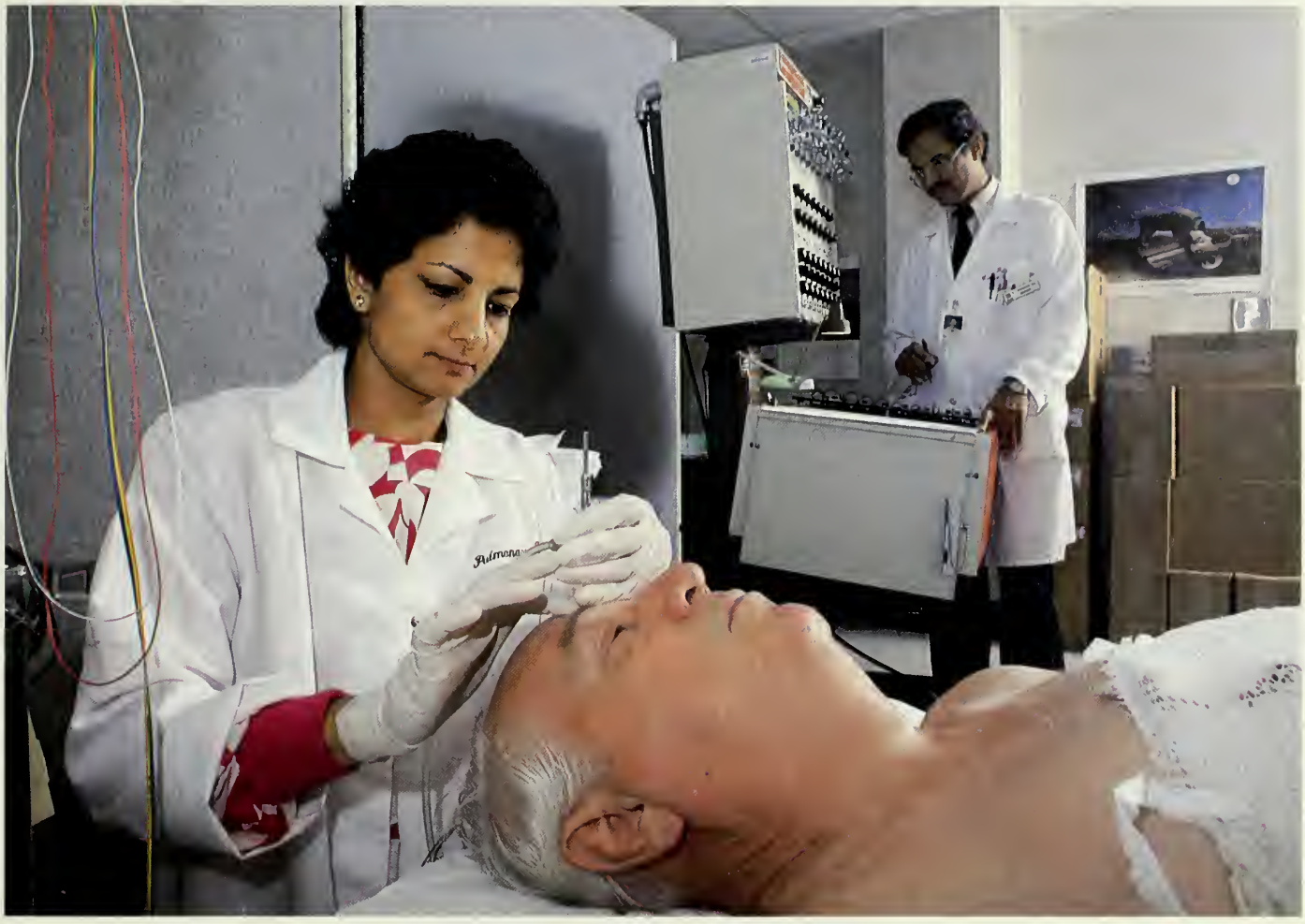
Apnea patients often have related abnormalities including an enlarged uvula, a usually small flap hanging above the tongue at the back of the throat; enlarged tonsils or adenoids, thyroid or jaw abnormalities or a broken nasal septum. These can be detected during a physical examination.

Obesity, cardiac arrhythmia, morning headaches and snoring are also common traits. Many apnea patients are 20 to 50 percent overweight, and some are morbidly obese. Snoring, while not always related to apnea, has been associated with high blood pressure and heart disease.

A snoring problem led Dublin, Ga., car dealer Donald Lawrence to seek medical treatment last fall. His physician referred him to Dr. Diane Davis of Macon, Ga., an MCG alumna and ear/nose/throat specialist. She examined Mr. Lawrence, found he had an elongated uvula and scheduled him for surgery to remove it.

But Mr. Lawrence postponed the operation because he did not think

Technician Shahnaz Dasti connects electrodes to patient Frank Kent as Dr. Bashir Chaudhary watches.



curing his snoring warranted surgery. Then his family physician discovered Mr. Lawrence had cardiac arrhythmia and hypertension. The surgery could help both conditions, the physician told him.

Mr. Lawrence underwent testing at the MCG sleep center last November. During the eight-hour testing period, he experienced about 131 apneas.

During testing, Mr. Lawrence was connected to electrodes measuring brain activity, eye movement, muscle tension, heart rhythm, air flow, chest and abdomen movement and oxygen saturation in the blood.

"It was hard to sleep with all those things," Mr. Lawrence said.

But most patients don't have any problem, said technician Shahnaz Dasti.

"Some patients fall asleep right away," she said. "They don't even know what I'm doing."

During the night, she records movements, coughing, snoring, posture and breathing as the monitor provides a continuous readout. The next morning, she and Dr. Chaudhary will evaluate the results.

Surgery, the chosen treatment for many apnea patients, proved beneficial for Mr. Lawrence. A postoperative test showed only seven apneas.

Uvulopalatoplasty, the surgical removal of excessive mouth and throat tissue, has cured about 60 percent of patients with obstructive sleep apnea, said Dr. Doug Harmon, the ear/nose/throat surgeon who performed the procedure on Mr. Lawrence at MCG.

Excess tissue blocks the patient's airway, causing obstructive apnea. Surgery removes the tissue and typically creates only temporary postoperative conditions, such as a more nasal quality of voice and reflux fluid from the nose.

Mr. Lawrence has been pleased with the outcome. He no longer snores, and the arrhythmia is nearly gone.

"It's just a whole different ballgame," he said. "Just for the snoring—it's great having that out of the way."

Mr. Lawrence's apnea was relatively mild. The patient previously mentioned has a more serious case. During the night's testing, he had more than 600 apneas, ranging from 10 seconds to more than two minutes. Dr. Chaudhary has referred him to Dr. Harmon for possible surgery.

Should there be no anatomic obstruction causing apnea, the patient may be a candidate for medical treatment. The most common treatment involves wearing a nose mask connected to an air source. This is called continuous positive airway pressure (CPAP) and forces air through the airway.

Another treatment originated at MCG can also be a simple one: sleeping on one side instead of on the back. The shift in position seems to allow air to bypass obstructions in the throat, Dr. Chaudhary said. Other treatments include using oxygen at night, using medications and tracheostomy, once common but now used only in rare instances.

A smaller number of apnea patients have central or mixed apnea. Central apnea occurs in patients with neurological problems, in which the brain's message to prompt breathing never reaches the muscles. Mixed apnea combines characteristics of both obstructive and central apnea.

COMPETITIVE EDGE

RESEARCH INSTITUTE HELPS MCG COMPETE FOR RESEARCH DOLLARS

Toni Baker

The Medical College of Georgia Research Institute is a hone that sharpens a competitive edge.

The competition is for the research dollar.

"One of the objectives of this office, the office of vice president for research, is to move us into the $20 million to $30 million extramural support range," says Dr. Lowell Greenbaum.

Today MCG's extramural support figure is $11 million.

"We were $7 million when we took over a few years ago," says Dr. Greenbaum, who became vice president for research in July 1985. "That's neat. But you've got to keep going. And this research institute is to keep things going."

The research institute is a sort of agent and backer in the complex world of securing dollars for research.

The fact that the research institute is the granting and funding agency simplifies a lot of things, says Dr. Greenbaum, who also is president of the institute.

When a researcher gets an idea and needs money to pursue it, with very few exceptions, it is the Medical College of Georgia Research Institute that applies for funds.

The researcher works for MCG and MCG has the resources and desire for research to be done, said Dr. J. Russell Claybrook, executive director of the institute.

"Those things make it advantageous for somebody to be an agent," he said. "The institute is really an agent working for MCG to apply for research funding."

When research dollars are received by the institute from some agency such as the National Institutes of Health, the research institute then subcontracts with MCG for the work to be done.

That in itself is a major role of the institute.

Patents and copyrights are the property of the institute, not MCG.

"Some things like confidential information on inventions may be less subject to public disclosure," Dr. Claybrook said.

"This is a very important part of the future because inventions coming out of the Medical College of Georgia, as they do from Georgia Tech and the University of Georgia, will stimulate new businesses as well as enhance established businesses," Dr. Greenbaum said.

Also, if MCG were the granting and contracting agency, it would be necessary to get Board of Regents approval for every grant application and contract agreement, he said.

But the institute may move swiftly ahead in pursuing research dollars.

If a discovery is made at MCG, the institute may even pay for a patent search as well as negotiate with a company interested in licensing a patent.

Recently, the institute negotiated with Chicago-based John O. Butler Co. which purchased exclusive worldwide rights to develop professional and consumer products using a discovery made by Dr. David Pashley, a Regents professor of oral biology at MCG.

The institute's role doesn't stop with securing outside dollars.

Major funders of research, such as the NIH, provide funds to cover the indirect costs of research, such as facilities and

Opposite: *Dr. J. Russell Claybrook* Below: *Dr. Claybrook meets to discuss research activity with (clockwise from top) MCGRI board members Dr. Lowell Greenbaum, Dr. Judson Hickey, Dr. Virendra Mahesh and Dr. Lois Ellison.*

personnel. These are resources supplied by MCG.

The research institute uses a portion of those indirect costs as a next egg for future research.

Through the institute's small grants program, money derived from indirect cost recovery is offered to MCG faculty on a competitive basis as an additional boost to their research.

One potential recipient is the faculty member who may need some seed money to get his research growing.

The other is for a researcher who gets a good priority score from a funding agency on his project idea but doesn't receive the money. For example, if the agency said the project needed more or a different type of experiment, the small grants program money could be used to get those experiments done and make the grant more competitive.

Both types of researchers must apply for the small grants of up to $10,000. Their applications are then reviewed by a study group, much like the process of NIH grant reviews.

"The two things are to give both the newly established investigator and the established investigator a more competitive application," Dr. Greenbaum said.

The program has provided nearly $1 million in small grants since its inception in 1980.

Dr. Greenbaum recently gave the institute another job.

A new incentive program makes up to $40,000 available to important research initiatives in areas such as AIDS or aging.

The institute offers up to $20,000 to a group of researchers interested in exploring a particularly compelling topic such as AIDS. MCG may then match the institute's contribution, bringing total dollars to $40,000.

Many large schools identify an important area of research, then recruit experts in the field. "The history of the school is that we don't do that," Dr. Greenbaum said.

"What we have to do is try and bring investigators together who have the capability on this campus and develop groups," he said.

"The research institute is important in bringing researchers together who grow together and develop large scale research programs."

The first such research initiative is on AIDS.

The AIDS group will explore how the AIDS virus attacks the body's immunological cells and destroys them. The group will look more specifically at one of the proteins in the AIDS virus that appears key to the virus' toxic effect on immunological cells.

AIDS research is very competitive, Dr. Claybrook said. The hope is that the institute's support will place MCG in a more competitive stance to receive funding from agencies outside MCG.

It's possible that two initiatives could be identified and funded each year, Dr. Claybrook says.

"We see a lot more investigators getting together now and beginning to work as part of this incentive program," Dr. Greenbaum said.

The bottom line of all the programs is competitiveness for the research dollar, the vice president said.

REFLECTIONS ON A PRESIDENCY

Toni Baker

Dec. 15, 1983, he'd only been on the job two weeks, but already the new president was telling the media that there would be changes.

Those comments set the tone for an administration that ended June 30, 1987, when Dr. Jesse L. Steinfeld stepped down from his job as president.

He'd waited until that last day to pack up the office and talk about his tenure as president.

He was prematurely leaving his job as fifth president.

Health problems mandated his leaving. He would have preferred to stay on.

He left a presidency marked by administrative streamlining, increased academic and research productivity and a new emphasis on planning. It also had its controversy.

He left June 30 with much accomplished, distressed only that his health kept him from completing the challenge offered by the students, faculty, Chancellor and Regents in his 1983 recruitment.

Dr. Steinfeld came to MCG at a time when it was clear that the national physician shortage of the '50s and '60s was over.

A scramble was on for competitive National Institutes of Health and National Science Foundation research dollars. MCG needed to enhance and demonstrate its ability to secure those dollars.

Opposite: *Dr. Jesse Steinfeld and his wife, Gen*

"To demonstrate our competitive ability to attract national research and education funds, we needed to start new programs and expand existing programs," Dr. Steinfeld said. "We needed to recruit additional faculty for these new and expanded programs. To accomplish this we reallocated existing resources, demonstrating both our commitment and our ability to be a force on the national scene," he said.

"An early priority in 1984 was to examine how resources were being spent. I looked at every contract that had money involved."

He found it was possible to save literally millions of dollars each year by renegotiating about 500 contracts.

"After contract negotiations, we had about the same level of educational exchange in almost every affiliation, except that the affiliations were more evenhanded and businesslike," Dr. Steinfeld said. "The Medical College, being a state agency, had in essence subsidized other organizations in the name of academics.

"Renegotiating contracts was not a win-win situation. It was a win MCG situation. It was not a win for those institutions and individuals who were no longer being paid for the privilege of academic affiliations and the stimulus of having health science students in their hospitals, clinics or offices," he said.

He looked further.

Staffing was cut in several areas that were overstaffed. That netted more than $1 million in savings every year to be spent on academic programs, faculty and student scholastic enrichment.

Another $1 million annual savings came in improved energy efficiency on the MCG campus. Part of the savings was possible because of computerization of energy activities on the large campus and the rest was the result of a disarray in OPEC, a plus not only for MCG but the entire United States, Dr. Steinfeld said.

He looked at monies received by MCG Hospital and Clinics and found that about $4 million in collectible funds, primarily from third-party payers, was not being received by MCG each year.

These collections and savings meant that more could be done to enhance MCG's academic, research and clinical programs without asking the state for more dollars.

For example, full-time faculty numbers went from 583 in 1983 to 637 in 1987, a 10 percent increase. Most of the new positions were in the School of Medicine. The increase was accomplished without receiving any new state-appropriated faculty positions.

During the same period, faculty salary increases were at or above the percentage level provided by state appropriations. Other institutions in the University System of Georgia were not so fortunate.

There were other pluses.

Salary adjustments were made for faculty in anesthesiology and physical therapy, for example, to make salaries at MCG more competitive regionally and nationally.

Dr. Steinfeld felt it necessary to attain or even exceed competitive regional and national salary compensation in order to attract and retain top-quality faculty at MCG.

Savings made possible major purchases such as the magnetic resonance imager. It also made new programs possible, such as establishment of the in vitro fertilization program in November 1984.

To strengthen MCG's efforts at research, Dr. Steinfeld placed a great importance on the need for faculty to do research. The phrase "publish or perish" was heard on campus. The position of vice president for research was established.

The MCG Research Institute was reorganized and strengthened during Dr. Steinfeld's tenure. A 54 percent increase in research support and a 13 percent increase in research publications have been the results.

All changes and new programs were part of an overall plan—a master plan that set priorities and goals for a stronger future.

Dr. Steinfeld doesn't want the master plan and facilities plan to be remembered as his.

The plan belongs to the Medical College of Georgia, he says. It was developed with the help of more than 250 MCG employees and the Augusta community and was endorsed by the Board of Regents.

Perhaps the most visible portion of the plan will be the needed buildings.

A $17.5 million outpatient care center and a $19.3 million specialized care center are part of the facilities plan.

The plan included the consideration that medicine is moving in two diverse directions—outpatient diagnosis and treatment when possible and inpatient care of the critically ill and injured.

"There was a consensus from MCG schools, deans, administrators, faculty and staff that if MCG was going to survive and, more importantly, thrive into the next century, it needed to be in the forefront of health care," Dr. Steinfeld said.

Also in the future is a children's medical center, planned for construction adjacent to the specialized care center.

The Steinfeld administration developed a method of paying for the outpatient center and specialized care center through the issuance of state bonds, with payment coming from revenue generated by MCG Hospital and Clinics.

If funding for the project had to wait for state dollars, it likely would have been 1992 before planning dollars were available. Under the Steinfeld planning system, construction could start in 1988.

Dr. Steinfeld is proud of these and other accomplishments, such as construction of two parking decks, a child care center and computerization of the library, in his three and one-half years as president.

He had these parting thoughts for the future.

"I hope MCG continues to improve at an ever-accelerating rate academically, in terms of research, in terms of the quality of patient care and new clinical programs needed to meet the challenges of the decades ahead," Dr. Steinfeld said.

"To be successful, MCG will need first-rate teaching and clinical facilities to match its existing excellent research facilities much more so than in the past.

"To steal a famous line, but one that is particularly appropriate of MCG, ask not what MCG can do for you, but what you can do for MCG and MCG's constituency," he said.

"I believe that the building plan will provide the needed physical resources. MCG also will require a significant amount of work and cooperation from students, faculty and staff to meet or exceed the technologic advances of the 1990s. We already have provided the necessary amounts of new funds for equipment and appropriate technologic support in all our calculations before allocating or committing any hospital revenues for two new buildings.

"The future should be bright," Dr. Steinfeld said. "But it will require all of our people working together."

Dear Alumni and Friends:

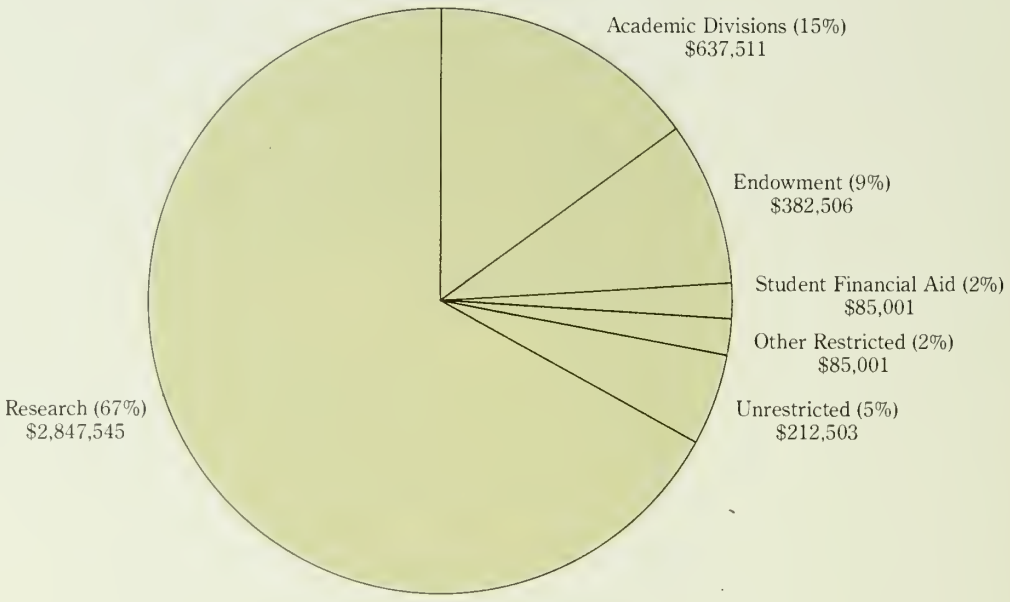
The mission of the Medical College of Georgia is to provide the citizens of Georgia and the Southeast with quality medical services through education, research and patient care.

The state provides approximately 50 percent of the total support for the educational activities at the Medical College of Georgia, and about 30 percent of the funds for hospital and clinic operations. In this context, the ultimate quality of the Medical College of Georgia rests with private support from alumni, friends, business and industry. Private giving and endowment income have enabled the Medical College of Georgia to position itself as a major health education center in the Southeast. These funds provide increased educational opportunities, allow continued recruitment of outstanding faculty and staff, help reduce the rising cost of medical education and assure the continuation of capital improvements. The men and women who attend the Medical College of Georgia deserve the very best in health education available today.

The common denominator behind all great educational institutions is a strong commitment from the private sector to provide those opportunities. You have helped further the Medical College of Georgia's academic distinction through your gifts. Annual support reached an all-time high of $4,250,067. A record 2,824 alumni participated, representing 26 percent of the alumni body, twice the national average for public institutions. All charitable contributions to the Medical College of Georgia are managed by the

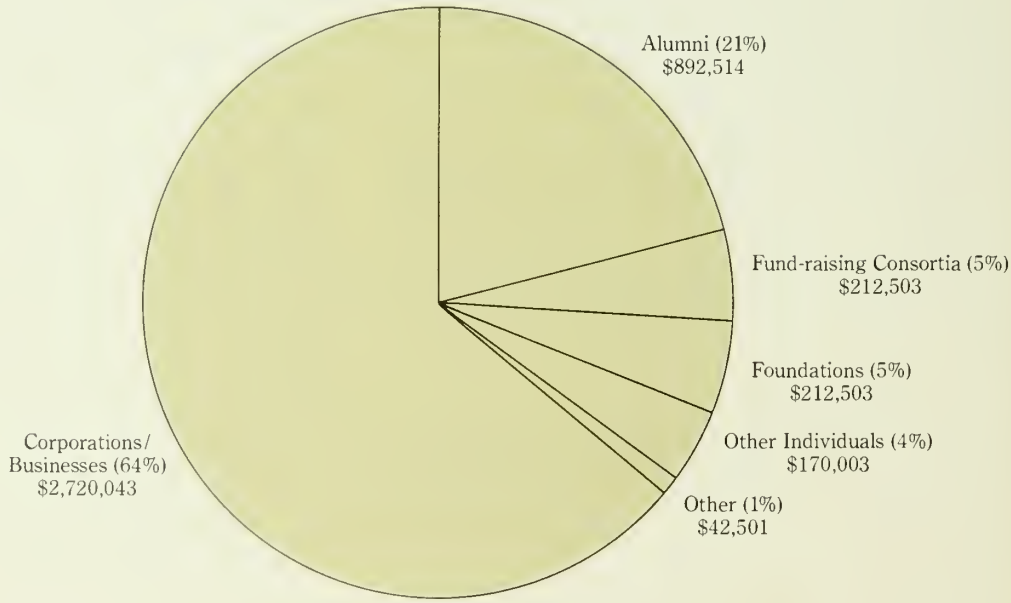
continued on page 26

1986–1987 Giving Report
BY DESIGNATION



TOTAL $4,250,067

1986–1987 Giving Report
BY DONOR SOURCE



TOTAL $4,250,067

Medical College of Georgia
Year Ended June 30, 1987
(With Comparative Figures for 1986)

	EDUCATIONAL AND GENERAL		AUXILIARY		1986
	Unrestricted	Restricted	ENTERPRISES	TOTAL	TOTAL
Revenue					
General Operations					
Resident Instruction					
Student Tuition and Fees	$ 4,640,024.60	$	$	$ 4,640,024.60	$ 4,225,989.80
State Appropriations	56,366,278.00			56,366,278.00	52,656,935.00
Indirect Cost Recoveries	1,957,893.38			1,957,893.38	1,789,816,38
Other Sources	102,709.48			102,709.48	57,129.96
Departmental Sales and Services					
Revenues from Program Support	2,720,898.55			2,720,898.55	2,495,569.58
Sponsored Operations					
Federal Grants and Contracts		7,404,404.32		7,404,404.32	7,054,538.81
State Grants and Contracts		3,230,717.09		3,230,717.09	2,359,058.07
Local Grants and Contracts					446,796.28
Private Grants and Contracts		12,198,376.68		12,198,376.68	11,218,567.37
Endowment Income		120,818.84		120,818.84	116,181.68
Hospital					
General Operations					
State Appropriations	29,438,910.00			29,438,910.00	30,357,685.00
Educational Department Sales and Services	79,878,172.45			79,878,172.45	71,846,093.31
Other Sources	50,246.03			50,246.03	83,266.35
Departmental Sales and Services					
Revenues for Program Support	2,234,355.19			2,234,355.19	1,613,984.19
Sponsored Operations					
State Grants and Contracts		5,049,233.29		5,049,233.29	4,586,580.30
Family Practice Residency Program					
General Operations					
State Appropriations	5,447,886.00			5,447,886.00	4,857,216.00
Desegregation Program					
General Operations					
State Appropriations	338,350.00			338,350.00	322,487.00
Georgia Radiation Therapy Center					
General Operations					
State Appropriations	1,375.00			1,375.00	184,549.00
Educational Department Sales and Services	1,640,390.90			1,640,390.90	1,517,867.25
Auxiliary Enterprises					
Student Housing			622,335.37	622,335.37	624,737.42
Food Services			585,149.09	585,149.09	652,414.72
Stores and Shops			1,528,241.65	1,528,241.65	1,428,825.81
Other Service Units			1,502,382.37	1,502,382.37	1,132,470.70
TOTAL REVENUE	**184,817,489.58**	**28,003,550.22**	**4,238,108.48**	**217,059,148.28**	**201,628,759.98**
Expenditures					
Educational and General					
Resident Instruction					
Instruction	44,278,594.67	14,022,072.31		58,300,666.98	53,845,760.72
Research		8,160,861.50		8,160,861.50	7,584,948.22
Academic Support	6,645,824.84	104,669,28		6,750,494.12	6,129,455.37
Student Services	1,066,647.12	9,239.40		1,075,886.52	1,041,096.77
Institutional Support	6,307,416.76	207,550.44		6,514,967.20	6,325,358.32
Plant Operation and Maintenance	7,481,991.49			7,481,991.49	7,222,096.83
Scholarships and Fellowships		449,924.00		449,924.00	323,361.00
Hospital					
Patient Care	96,581,099.36	5,049,233.29		101,630,332.65	93,270,199.59
Hospital Support	6,712,721.39			6,712,721.39	5,876,410.24
Plant Operation and Maintenance	8,140,205.48			8,140,205.48	7,659,274.56
Family Practice Residency Program					
Instruction	5,332,058.69			5,332,058.69	4,800,085.73
Scholarships and Fellowships	86,000.00			86,000.00	
Desegregation Program					
Instruction	242,939.29			242,939.29	227,570.13
Scholarships and Fellowships	95,352.67			95,352.67	94,754.31
Georgia Radiation Therapy Center					
Instruction (Patient Care)	1,514,613.53			1,514,613.53	1,567,135.79
Plant Operation and Maintenance	127,598.34			127,598.34	125,812.18
Auxiliary Enterprises					
Student Housing			603,687.40	603,687.40	577,399.78
Food Services			835,830.83	835,830.83	848,106.97
Stores and Shops			1,416,907.51	1,416,907.51	1,310,309.73
Other Service Units			1,094,303.32	1,094,303.32	885,047.32
TOTAL EXPENDITURES	**184,613,063.63**	**$ 28,003,550.22**	**3,950,729.06**	**216,567,342.91**	**199,714,183.56**
Excess of Revenue Over Expenditures	204,425.95		287,379.42	491,805.37	1,914,576.42
Beginning Fund Balance	100,072.82		(39,349.01)	60,723.81	(1,435.76)
Adjustments Other Than State Audit	195,044.63		1,192.38	196,237.01	237,089.24
Lapsed Surplus Returned—Prior Year	(100,072.82)			(100,072.82)	(42,565.21)
Provision for Reserves	(302,853.45)		(226,789.67)	(529,643.12)	(2,046,940.88)
ENDING FUND BALANCES	**$ 96,617.13**		**$ 22,433.12**	**$ 119,050.25**	**$ 60,723.81**

continued from page 24

Foundation which employs the services of The Citizens and Southern Bank, First Atlanta Bank and First Union Bank to invest these gifts.

Any successful philanthropic endeavor must have the right combination of volunteer leadership and professional staff support. With the assistance of talented and enthusiastic volunteers, the Medical College of Georgia is beginning to realize a very promising comprehensive private giving program.

Regional alumni dinners are enjoyable and informative because of the willingness of local chairmen to sponsor the event. These gatherings encourage communication between the college and its graduates, keeping each informed of the other's achievements both personally and professionally. Examples of special events include the Children's Miracle Network Telethon, the Georgia-Carolina Arabian Horse Show, and the Augusta Children's Pro-Am. Other volunteer support has been utilized on various fund-raising projects including the Pund Chair in Pathology, the Moretz Chair in Surgery, the Family Practice Chair and other constituency group projects.

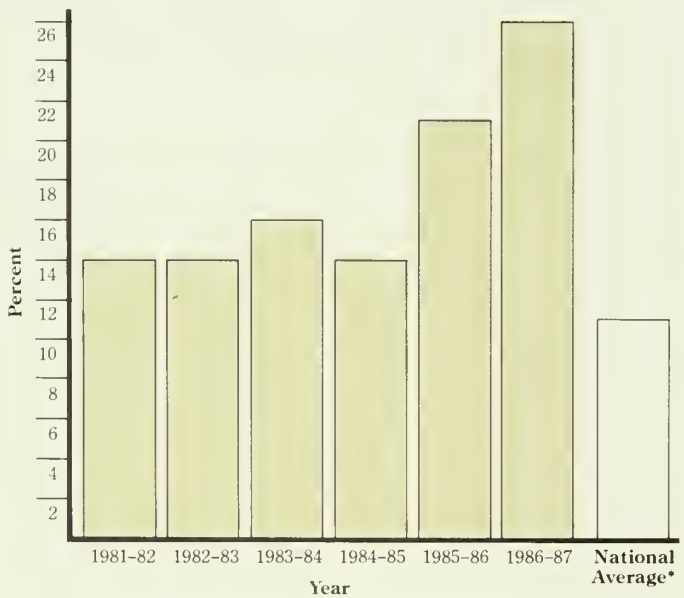
The year 1988 marks the Medical College of Georgia's 160th anniversary. Your continued support helps strengthen the Medical College of Georgia's commitment to excellence as we prepare for the college's next 160 years of service.

Very cordially yours,

John T. Anderson

John T. Anderson
Vice President for Development

Percentage of Alumni Who Contributed 1981–1982 through 1986–1987



Year	Total living/ located alumni	Total alumni donors	Percentage
1981–82	9,245	1,280	14%
1982–83	9,680	1,324	14%
1983–84	9,595	1,526	16%
1984–85	12,900	2,016	14%
1985–86	11,075	2,311	21%
1986–87	8,815	2,284	26%

*Based on Council for Financial Aid to Education 1985-86 survey of public comprehensive institutions.

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Victor Mills (left) and Brook Simmons (far right) applaud as John Anderson presents check to Mike Harmon, winner of the 1987 Children's Pro-Am Golf Tournament.

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55	4440	670	475	195
60	4594	700	476	224
65	4856	730	472	258
70	5106	780	472	308
75	5404	850	479	371
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85	5820	1140	525	614
90	5903	1400	564	836

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